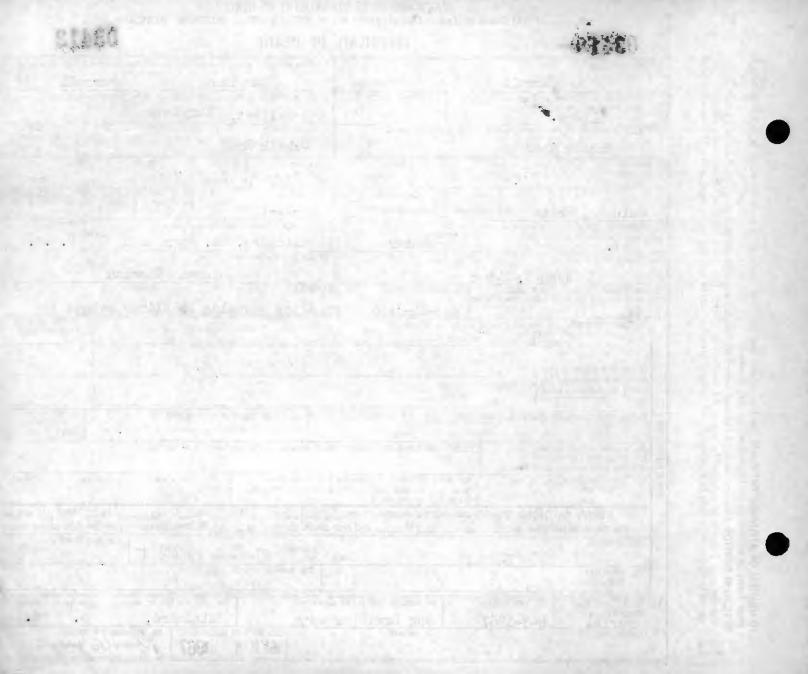
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 -CERTIFICATE OF DEATH and 2 executed within 24 hours after death the funeral 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH b. COUNTY Balto. City o. COUNTY Carroll Maryland physician ampletely filled in by the functor physician papers. Pages 1 ion phease remave carban papers. Pages 1 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c. CITY OR TOWN (if outside carparate limits, write RURAL and give nearest town) 11 Mos. Balto. City 30 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NO TY YES Lauretta Ave Springfield State Hospital NAME OF 4. DATE Dov Year Last DECEASED (Type or print) Sidney Edgar Armiger DEATH March 9. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS. 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED lost birthdoy) Months Hours DIVORCED White WIDOWED L-18-15 Male 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12 CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? INDUSTRY U.S.A requires that the death certificate Painter Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME the attending phys ar remaya Sydney Edgar Armiger Grace Rice IS. WAS DECEASED EVER IN ILS. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give war or dates of service) Lauretta Ave. Springfield St. Hosp. Records MAKAGWAX Nene cremation, INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the burial-transit p burial, crematia ONSET AND DEATH PART I, DEATH WAS CAUSED BY Mycardial infarction. IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove Pulmonary tuberculosis. (b) Vears rise to immediate couse (a), DUE TO stoting the underlying couse attending has been lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) for use Health Schizophrenic reaction, chronic undifferentiated type. NO by the haspital ar this certificate 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item IB.) OR CONTRIBUTING CAUSE OF DEATH detached be detached State Dept. ((IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (State) 20d. INJURY OCCURRED (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) Not While at work O FUNERAL DIRECTOR: After of work 21. I certify that (1) (this haspital) attended the deceased from 4-25-66 , ta 3-5-67 __, 19____, that (1) (we) last shauld ro Hospital or Attent Page 4 may be retained and that death occurred att.: 15aM, from causes and an the date stated above. sow the deceased olive on_ 3-5-67 19 . 220. SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR bd directar, page 3 should be filed PHYS. 22d. ADDRESS 22c. PHYSICIAN'S Springfield State Hospital NAME (Type) Julian Radzykewycz, M.D. Sykesville, Maryland 2178 23d. LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION, 23b. DATE THEREOF (County) (Stote) Burral (Specify) Loudon Park Cem. Baltimore. Md. 3-7-67 25b. REGISTRAR'S SIGNATURE **ADDRESS** 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VE A15 (4) 20 M 1/66 Witzke F.D.-4101 Edmondson Ave. 1967

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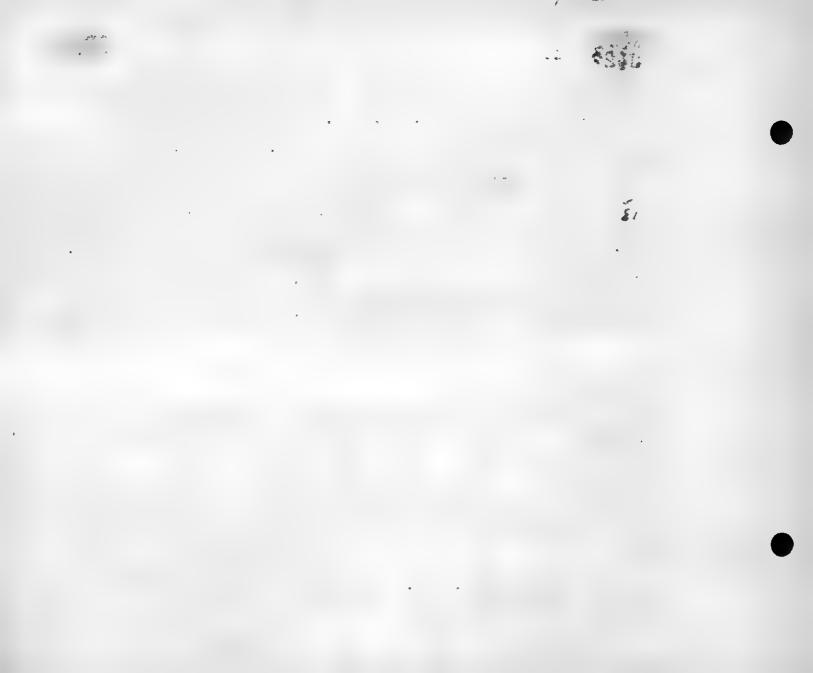
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	G & death. Page .	FOFUNERAL COTOR: After this certificate has been signed by the attending physician and completely	5	E be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any every high 72 ho
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03420	CERTIFICAT	E OF DEATH	03414
1. PLACE OF DEATH	1	2. USUAL RESIDENCE (Where decease	d lived, if institution, Residence before edmission)
CARROLL	MARYLAND	MARYLAND	b. COUNTY ARRELL
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest lown)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate	limits, write RURAL end give nearest town)
MESTMINSTER d. NAME OF HOSPITAL OR INSTITUTION (II PO)	in hornital, give street address)	NESTMINS	ER 10. IS RESIDENCE
185 WILLISST	in norphy, give most egyless;	185 WILL-15 5	ON A FARM? YES NO P
3. NAME OF DECEASED (Type or print) WESLEY	CLAYBAUGH B.	ROOKS 4. DATE OF DEATH	Month Day Yeer MARCH 10 1967
	ARRIED NEVER MARRIED B.		E (In years IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work		OV. 19 1890 7	6 yrs.
done during most of working life, even if retired) CLAIMS ADJUCTOR FIX		MESTMINSTER	MO 4.5.9.
13. FATHER'S NAME	nalle	14. MOTHER'S MAIDEN NAME	NELL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Hyes give werer detes of service)		VFORMANT	Address
100		C.L. BILLINGSLEA WE	
18. CAUSE OF DEATH [Enter only one cause PART I. DEATH WAS CAUSED BY:	e per line for (a), (b), and (c),]		INTÉRVAL BÉTWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	bunice Con	~ d	3-8-47
422/ DUE TO 1		A 1	•
Conditions, if eny, which (b) (b)	andio-nenal	- varenter di	sense year
(e), stating the underlying DUE TO	malincement	raine brenchi	tis 5 years
		RELATED TO THE TERMINAL DISEASE CONT	
Contenu	io- zelerosi	7	PERFORMED?
		(Enter neture of injury in Pert I or Pert II of ite	om 18.)
20c. TIME OF INJURY Month, Day, Yeer Hour a.m.		CE OF INJURY (Home, ferm, 20f. (City or to ry, street, office bldg., etc.)	(Stete) (County)
	attended the deceased from	-10 1966 to 3	
			causes and on the date stated above
22e. SIGNATURE	elen M.	a number of a superson of all	22b. DATE SIGNED SYS. 3-10-67
22c. PHYSICIAN'S NAME (Type) C. Lc. 13:117	ngslea	Westmins	ter, maryland
236. BURIAL, CREMATION, 236. DATE THEREOF	23c. NAME OF CEMETERY C	OR CREMATORY 23d. LOCATION	(City, town or county) (Stele)
BURIAL 3/13/67	WESTMINSTER	CEMETERY WES	TMINITER MY
24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS ADDRESS	MAR 1 4 1967	256. REGISTRAR'S SIGNATURE
V 7 11/10/10/10/10/10/10/10/10/10/10/10/10/1	1 VIII WIRELLY 1	Mar Dallette T T 1001	

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03421 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. and signed by the attending physician and campletely fulled in by the funeral burial-transit permit. Then please remaye carbols, papers. Pages I and burial, cremation, or remayal, and in any events, within 72 hours after death 2 USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) PLACE OF DEATH b. COUNTY Baltimore City o COUNTY o. STATE Carroll
b CITY OR IOWN (If outside corporate limits, MARY! AND Marvland C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Baltimore lyrs.7mos.19dys Sykesville e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS 2313 N. Charles St. Springfield State Hospital YES NO DE 3 NAME OF First 4 DATE Doy Year DECEASED RUTH (Type or print) BROWN DAN FORTH DEATH MARCH B DATE OF BIRTH 9 AGE (In years IF UNDER TYEAR IF UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED **NEVER MARRIED** birthdoy) Months Dovs Hours 9-28-1884 WIDOWED DIVORCED Female White 10o LSUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working He, even if refired)

Dept. Store Work COUNTRY? INDUSTRY Maryland II S 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Dan Forth Unk. IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT Address 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or doles of service) 215-03-0258-D Records, Springfield State Hospital 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH Mesenteric thrombosis Davs IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stoting the underlying couse as the Page 4 may be retained by the hospital ar attending O FUNERAL DIRECTOR: After this certificate has been PART 11, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? Chronic brain syndrome with cerebral arteriosclerosis, with psychotic NO X reaction far 200 ACCIDENT WAS UNDERLYING [205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (County) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (Stote) 20c TIME OF INJURY Month, Doy, Year Not While foctory, street, office bldg., etc.) Hour o.m. 21. I certify that (I) (this haspital) attended the deceased fram. and that death occurred at 7-14-63 19....., that (1) (we) last 3-3-67 W. from causes and an the date stated above. saw the deceased alive an. 22b. DATE SIGNED 22a SIGNATURE ATTENDING MED. DIRECTOR 3-3-67 SM.D. PHYS. Springfield State Hospital 22d. ADDRESS 22c. PHYSICIAN'S Antonius Glahn, M. D. NAME (Type) Sykesville, Maryland director, shauld 230 BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) y Kesville eedom 25b. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR **FUNERAL DIRECTOR** Charles VR A15 (4) 3 20 M 1/66



	(11)		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, 1	MADVI AND
/	4 70 4		03422 CERTIFICATE OF DEATH	N3416
	after death. the funeral ges 1 and 2 after death.		1. PLACE of DEATH a. COUNTY Carrall MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If institution: a. STATE b. COUNTY MARYLAND MARYLAND	Residence before admission)
,	in by		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 12 days Westmuster Rd. 4	
	24 fille n 7	2	Ana View Musingfome Sic	O. IS RESIDENCE ON A FARM? YES NO 2
	ompletely carbon vent, withi	-	3. NAME OF DECEASED (Type or print) G. COLOR OR RACE 7. MARRIED NEVER MARRIED 18. DATE OF BIRTH 19. AGE (IN YEARS LIFTUNDE	Day Year // 1967
	executed that and compared to any even	/	MALE White WIDOWED DIVORCED 4/14/92 Hast birthday) Months	
	ate ber hysician please al, and i	d	Jas States Name (14. MOTHER'S MAIDEN NAME) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	GITIZEN OF WHAT COUNTRY?
	death certificate be/e ne attending physiciam permit. Then please r ion, or removal, and in		EZRA BYERS MARY YINGLING- 15. WASDECEASED EVER INUS ARMED FORCES? LIS SOCIAL SECURITY NO. LIZ INFORMANT Address	
	death the atte permil	=	(Yes, no., or unkown) (If yes give war or dates of service) 216-01-1785 Mks. Jonnes Haines Westm 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	inster M
	that the sician. ned by tall-transital, crema		PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Candia United	ONSET AND DEATH
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	N: The law rectal or attendir tificate has be for use as the f Health prior t	CERTIFICATION		YES NO X
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	oling PHY of by the After this of be deta e State De	MEDIESI		ounty) (State)
	r ATTEN r retaine RECTOR: 3 shoul with the			
	TO HOSPITAL OF Page 4 may be to FUNERAL DIF director, page should be filed		22c. PHYSICIAN'S NAME (Type) WICHENN SPEICHER MD 122d. ADDRESS 1356 Walling	-1/-6/
	Page 10 Fig. Should should be should		3a. BURIAL, CREMATION, 23b. DATE THEREOF 123c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or conservation) 3/14/6 7 Andrew Cemeter, Roman for the Funeral Director Address 25a. REGISTRAR 25b. REGISTRAR 25b. REGISTRAR	ounty) (State)
	VR AIS (4) 20M I/65	_	J. S myrs, Jr. Westminter md MAR 1 4 1967 Jolianla	Judge :



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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03424 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. brace or filled in by the funeral ve corban papers. Pages I and event, within 72 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY Carroll Maryland MARYLAND b CITY OR TOWN (If outside corporate limits, C. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside carparate limits, write RURAL and give negrest town) write RURAL and give nearest town)
Rural-Sirkesville Rural-S-kesville Life d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENC ON A FARM? R.D. 2 Un R.D. YES THE NO T 3. NAME OF First Middle Lost 4 DATE Month Day Year DECEASED OF Corroll E. Cook March 1957 (Type or print) DEATH S SFX 9. AGE (In years IF ISNDER 1 YEAR I IF UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BIRTH last birthday) Davs Oct.3.1890 Hours Male Colored ond in ony WIDOWED DIVORCED physician ond 11 BIRTHPLACE (County & State, or foreign country) 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even fretired) COUNTRY? INDUSTRY Carroll Co., Mid. 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME James Cook Phoebe Myers WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, ng. or unknown) (If yes give war ar dates af service) 17-16-5 Mrs. Daisy M. Cook Same As INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), signed by the burial-tronsit p PART | DEATH WAS CAUSED BY ONSET, AND DEATH IMMEDIATE CAUSE (o DUE TO Conditions, if ony, which gove rise to immediate cause (a). DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been the WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES [NO F وز 205, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20a ACC DENT WAS UNDERLYING □ detoched for the perior of the period of the OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20c TIME OF INJURY Manth, Day, Year (City or town) (County) (State) Not While Haur a.m factory, street, affice bldg, etc) at work 21. I certify that (I) (this hospital) attended the deceased fram. ro Hospital or Attend Poge 4 may be retoined and that deoth occurred ot_ M, from causes and an the date stated above. saw the deceased olive on 22b. DATE SIGNED 220/ SIGNATURE ATTENDING PHYS \square director, page 3 should be filed v M.D. DIRECTOR PHYS 220 ADDRESS 22c. PHYSIČIAN'S NAME (Type) 23a BUR AL, CREMATION, REMOVAL (Specify) 23b DATE THEREOF 23r. NAME OF CEMETERY COM 23d. LOCATION (City or Tawn) (County) (State) Carroll 250 REC D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Waltz Fox 241 Sykesville.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 24 hours after death, anddeatl PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY ALTO / MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) .⊑ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address d. STREET e. IS RESIDENCE ON A FARM? Nursina remove carbon par any event, within 020 Home NO V YES within completely NAME DE Middle DATE Month Day Year DECEASED (Type or print) DEATH 23 19 67 SEX 6. COLOR OR RACE AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS 7. MARRIED NEVER MARRIED DATE OF BIRTH last birthday) Months Hours and WIDOWED Y DIVORCED [vrs. attending physician a ermit. Then please le in, or removal, andin 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) CITIZEN OF WHAT during most of working life, even if retired) death certificate be COUNTRY? INDUSTRY e Acher S 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME UnKnowN UNKNOWN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? transit permit. 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) (If yes give war or dates of service) Νο CAUSE OF DEATH [Enter only one cause per line for (a). PHYSICIAN: The law requires that the INTERVAL BETWEEN been signed by the burial-transit or to burial, crema ONSET AND DEATH PART I. DEATH WAS CAUSED BY: be retained by the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) 38 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIGOTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health PERFORMED' certificate NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part | or Part || of Item 18.) detached for the details of the deta MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. at work at work p.m. P 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should led with the saw the deceased alive and that death occurred at M. from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED page ATTENDING PHYS. an M.D. DIRECTOR Page 4 may O HOSPITAL PHYSICIAN'S FUNERAL 22d. ADDRESS director, p should be 1 NAME (Type) BURIAL, CREMATION, 23b. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) 23c. 23d. (State) REMOVAL (Soecify) ADDRESS **FUNERAL DIRECTOR** REGISTRAR 25b. REGISTRAR'S REC'D BY VR AI5 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS. 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF BEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY a. STATE Carroll Maryland Montgomery MARY! AND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b 5yrs.5mos.5dva Sykesville Dyl's olive street address)
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Gaithersburg e. IS RESIDENCE d. STREET ADDRESS ON A FARM? ay is 3 to i State Cedar Ave., Ext. Springfield State Hospital No X YES: NAME OF DATE Year First Middle Month DECEASED GRIGGAR PHILIP B. 1967 (Type or print) DEATH MA R.CH 6. COLOR OR RACE | 7. MARRIED 5. SEX AGE (in years | IF UNDER 1 YEAR | IF UNDER 24 HRS 8. DATE OF BIRTH NEVER MARRIED last birthday) Months Days Hours Male White 2-12-1892 WIDOWED F DIVORCED To 10a, USUAL OCCUPATION (Give kind of work done | 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? Janitor - Gaithersburg High School Virginia 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Criggar Phillip Cregger Mary Fulter 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unkown) (If yes give war or dates of service) permit. No 229-03-9009 Records, Springfield State Hospital INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Acute myocardial infarction 0 Minutes cremation. Severe coronary arteriosclerosis with insufficiency Conditions, if any, which gave rise to immediate DUE TO cause (a), stating the underlying cause last, ed as burial, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? CBS associated with alcohol intoxication, without qualifying phrase YES D DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.) 20a. EXTERNAL CAUSE WAS PRIMARY TO OF CONTRIBUTING TO CAUSE OF DEATH. patient found slumped by bed; pronounced dead at 5:35 PM.
20d. INJURY OCCURRED | 200. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) MEDICAL (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. Not While at work at work p.m. 21. I certify that I took charge of the remains described above, held an Autopsy , Inspection Inquiry and in my opinion shoul Undetermined manner Natural causes x/ Suicide Homicide death resulted from: Accident the CHIEF MEDICAL EXAMINER 22. DATE SIGNED ACTUAL ASSISTANT MEDICAL EXAMINER SIGNATUR DEPUTY MEDICAL EXAMINER director. retained NAME (Type) Glenn Speicher. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY Monte. Rockville. Proklayn Buria 254, REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Rockville VR A15ME he ler Funer 1 Home tockville, DATE 35DD 4-64

Vin No.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH death PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence I. PLACE OF DEATH complétely filled in by the fundr navel calibon papers. Pages 1 an o. STATE Maryland COUNTY b. COUNTY after Carroll MARYLAND Montgomery c. LENGTH OF STAY IN 16 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hauss Chevy Chase Limos . 3dvs . Sykesville papers. hm 72 ha d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e. IS RESIDENCE ON A FARM? 4817 Chevy Chase Blvd. K ON Springfield State Hospital YES 🗍 Middle 4. DATE 3. NAME OF First Lost Month Doy Year DECEASED MARCH 13 67 CLARA LOUISE DECKER 19 (Type or print) DEATH IF UNDER 1 YEAR 9. AGE (In years IF UNDER 24 HRS S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B. DATE OF BIRTH 6 last birthdov) Months Dovs Hours White 6-5-1874 Female or remayal, and in any X WIDOWED DIVORCED 106 KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT 100 LSUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife INDUSTRY COUNTRY? Ohio II.S.A 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Charles Plaisted Sarah Mc:Lean 17. INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. permit. (Yes, no or unknown) (If yes give wor or dotes of service) 579-60-4294 Records, Springfield State Hospital būrial-transit perr burial, crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Days signed by Page 4 may be retained by the haspital ar attending physician. Arteriosclerotic cardiovascular disease Conditions, if ony, which gove Years rise to immediate couse (a), DUE TO stating the underlying couse as the priar tal this certificate has been Minimal pulmonary tuberculosis, active Months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CBS assoc. with senile brain disease, with psychotic reaction WAS AUTOPS PERFORMED? use NO DC YES <u>_</u> 205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While 19 ot work TO FUNERAL DIRECTOR: After of work 21. I certify that (I) (this haspital) attended the deceased fram 11-10-66 3-13-67 , 19___, that (I) (we) last shauld I ith the S saw the deceased alive on 3-13-67 and that death accurred at M. fram causes and an the date stated above. 22b. DATE SIGNED 220 SIGNATURE ATTENDING 3-14-67 DIRECTOR . director, page Shauld be file 22d. ADDRESS Springfield State Hospital /22c. PHYSICIAN'S Julian Radzykewycz, M. D. NAME (Type) Sykesville, Maryland 23d. LOCATION (City or Town) (County) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 230. BURIAL CREMATION, REMOVAL (Specify) 3-16-1967 Cedar Hill Cemetery Buriel Gawle Joseph Wash. Inc. Wisc. Ave. 5130



اليسي	1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND	n
2	4 78 NE	03428 CERTIFICATE OF DEATH	2
	funeral death.	1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before	e admission)
		CARROLL MARYLAND B. COUNTY CARROLL	_
	irs after by the Pages: urrs after	b. CITY OR FOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER	irest town)
	24 hours filed in by apers. Pa n 72 hours	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS i.e. IS R	RESIDENCE
	n 24 y fills pap hin 7	141 WI MAIN ST. YEST 141 W. MAIN ST. YEST	A FARM?
	xecuted within 24 hours and completely filled in by genove carbon papers. Pagany-event, within 72 hours	3. NAME OF DECERSED (Type or print) ELSIE AGNES DUTTERER OF DEATH MARRIED LAST	Year
	somp ee ca		19 6 7
	executed and com	FEMALE WHITE WIDOWED DIVORCED MARCH 12 1889 last birthday) Months Days Hou	urs Min.
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR library and state, or foreign country) 12c. CITIZEN OF WE COUNTRY?	TAH
	ate hysic plea il, a	HOUSE WIFE CARROLL CO. MD U.S.C.	2
	certificate be unding physician Then please removal, and in	WILLIAM K. LEPPO AMELIA C. FRIDINGER	
	h ce tendi iit, or re	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITYNO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service)	
	death he atte permit tion, or	- 219-34-490X MRS LILLIE MAY PETRY, LITTLESTOR	UN PA
	y the	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART J. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCEL BALLE BLUE LINE (A) ONSET AN (WA)	BETWEEN ID DEATH
	that sicial mal-tra al-tra	1561 DUE TO CO'S A STATE OF THE TOTAL OF THE	
	phy phy n sig	Conditions, If any, which gave rise to immediate (b) which the Mellitus	
	requir	cause (a), stating the OUE TO The OUE TO	urs
	atten atten has e as h prio		AUTOPSY
	N: The latificate hit for use I Health i	YES T	ORMEO?
	PHYSICIAN: The law requires that the hospital or attending physician, this certificate has been signed betached for use as the Burial-trane Elept. of Halith prior to burial, cre	PART II. O THER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS PERF YES 20a. ACCIDENT WAS UNDERLYING TO DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	PHYS the range of the let and the let let let let let let let let let le	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) factory, street, office bldg., etc.) p.m. 19 at work at work	(State)
	E te to E		
	S.E & E 5	21. I certify that (I) (this hospital) attended the deceased from a first 1963, to March 4 1967, that (I) saw the deceased align on March 3 1967, and that death occurred at 665 M, from the causes and on the date state) (we) last ted above.
	OR ATTE be retail URECTO le 3 sen ell with	22a. SIGNATURE 22b. DATE SIGNED ATTENDING MED. STAFF 3	
	TAL OR may be tal. DIR.	22c. PHYSICIAN'S 12d. ADDRESS 12d. ADDRESS	Z
	HOSPITA age 4 mil FUNERAL irector, i	NAME (Type)	
	TO HOSPITAL OR ATTI Page 4 may be retain TO FUNERAL DIRECTO director, page 3 sm should be filed with	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)	(State)
	- = Q	BURIAL 3/7/67 WRIDERS CEMETERY RURAL, WESTMINSTER 24, FUNERAL DIRECTOR ADDRESS 125a. REC'D BY REGISTRAR'S SIGNATURE	10-
	VR A15 (4)	I-murso, & lotatomista ml - DATE MAR 7: 1967 Policylas D	udas
	20M 1/65	g fight the same of the same o	=



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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. COUNTY a. STAJE b. COUNTY Carrol1 Carrol1 MARYLAND cessary, funeral may be b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Life Rural. Westminster Rural. Westminster 5 5 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? lay is 3 to t Page 10 Westminster, Md. R. D. 1 Westminster. Md. R. D. 1 NO X YES 2, and PM3. NAME OF Middle Last Month DECEASED 3/15/67 DEATH (Type or print) 19 5. SEX 6. COLOR OR AGE (In years | IFUNDER 1 YEAR UF UNDER 24 HRS. after death. If a Give Pages 1, ong with form last birthday) | Months | Davs Hours Male White WIDDWED . 8/27/1889 DIVORCED (N 10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Retired Farmer Carroll County, Maryland, U.S.A. аюпд Fa.m. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME in Sa Jerome Dutterer Bllen Hull File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Address 16. SOCIAL SECURITY NO. 17. INFORMANT R. D. 1 (Yes, no, or unkown) (If yes give war or dates of service) permit. removal. No Mrs. L. Oliver Dutterer, Westminster, Md. 219-20-235**7** 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: burial-transit cremation, or IMMEDIATE CAUSE (a DUE TO Conditions, if any, which (b) should be gave rise to immediate DUE TO cause (a), stating the æ underlying cause last. used as to burial, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY FICATION PERFORMED? YES ND 🔽 DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.) 20a. EXTERNAL CAUSE WAS CERT PRIMARY | or CONTRIBUTING should | ent, pri CAUSE OF DEATH. 3 sho MEDICAL 20d. INJURY OCCURRED 12De. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 2Dc. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. Not While at work at work L Inspection X. Inquiry and in my opinion the cert 21. I certify that I took charge of the remains described above, held an Autopsy Undetermined manner Natural causes X. Accident Suicide Homicide death resulted from: RECTO CHIEF MEDICAL EXAMINER Your Page ASSISTANT MEDICAL EXAMINER 9 DEPUTY MEDICAL EXAMINER AND **EXAMINER'S** Address (Street, by Cover or obubly) director. NAME (Type) LOCATION (City, town or county) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 3/18 0 St. Marys Cemetery Silver Run, Carroll Co. Burial 25b. REGISTRAR'S SIGNATURE 25a. REC'D BY REGISTRAR ADDRESS VR A15ME Littlestown. Pa 3500 4-64



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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) delay 12 de 13 to a. COUNTY a. STATE **b.** COUNTY after death. Carroll Marvland Carroll MARYLAND C LENGTH OF STAY IN 16 c CTY OR TOWN (If autside corparate finits, write RURAL and give nearest town) b CITY OR TOWN (I outside carporate limits puo wr.te RURAL and give nearest town) 4 months Finksburg (rural) Finksburg -rural d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? with the State Dep within 72 hours a olong with form 18 Give Pages 1, RD2 YES NO X RD2 3 NAME OF Midd e 4 DATE Year DECEASED 3 Edmondson 67 EX DEATH 19 (Type or print) James IF UNDER 24 HRS 9 AGE (In years IF UNDER 1 YEAR S SEX 6 COLOR OR RACE 7 MARRIED X NEVER MARRIED DATE OF BIRTH Months Days iost b rthday) Hours 16, 1942 WIDOWED DIVORCED white 24 hours male pencil in There 10a USUAL OCCJPATION (Give kind of work done 11 8!RTHPLACE (State or foreign country) 10b KIND OF BUSINESS OR 12 CT ZEN OF WHAT during most of working life, even if retired)

Tree frimmer Carroll Co., Md. pages I rd "pending" in pencil in Chief Medicol Exomine 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME be executed within Unknown Helen V. Edmondson and Sampaddias 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give war ar dates of service) 219-36-1032 removol. Edmondson Mrs. Margaret 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), ond (t).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN burnol-fronsit ONSET AND DEATH Carbon monoxide poisoning associated with smoke used as a bunal-trans bunal, cremation, or This certificate should e, writing the ward farwarded to the Ch and soot inhalation DUE TO-Conditions, if any, which gave rise ta immediate cause (a), DUE TO stoting the underlying cause WAS AUTOPS PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? please execute the certificate. 5 may be retained by FUNERAL DIRECTOR: Page 3 should be a Health or its designated agent, prior to NΘ 20g EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of invery in Park or Port II of item 18.) PRIMARY Sor CONTRIBUTING 4 should ELCAL EXAMINER: conflagration CAUSE OF DEATH. 20d INJURY OCCURRED 20f (City or fown) 20c TIME OF INJURY Month, Day, Year 20e PLACE OF INJURY (Home, form (County) foctory, street, office bldg, etc.)
trailer park of work x Finksburg-rural, Carroll, Md. 19 67 at work 21. I certify that I toak charge of the remains described above, held an Autopsy [X]. Inspection . Inquiry [and in my apinian Accident K Suicide . Hamicide Undetermined manner death resulted from Natural causes CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURI TO DEPUTY DEPUTY MEDICAL EXAMINER 3/2/67 Werner U. Spitz, M.D. NAME (Type Address (Street, city, town, or county) 23b DATE THEREOF 230 8 JR.AL, CREMATION. 23c. NAME OF CEMETERY OR ENEMATORS 23d EOCATION (City or Town) REMOVAL (Specify) Providence Cenetery Carroll Co., lid. 25b. REGISTRALS SIGNATURE Judge ADDRESS 2So. REC'D 8Y REGISTRAR 24 FUNERAL DIRECTOR Waltz Box 241 Sykesville, Md. 1967 VR A15ME (\$)



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH deoth.] ond PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a COUNTY a. STATE b. COUNTY MARYLAND physician and completely filled in by the 1 E LENGTH OF STAY IN 16 corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits CITY OR TOWN write RURAL and give nearest town requires that the death certificate be executed within 24 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in haspitol, give street oddress d STREET ADDRESS within 72 NO 3. NAME OF 4 DATE First, Month Year DECEASED DEATH (Type or print) YEAR IF UNDER 24 HRS F UNDER S. SEX AGE (in years 6. COLOR OR RACE 7 MARRIED **NEVER MARRIED** DATE OF BIRTH Months last birthday) Doys Haurs WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done TOO KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY HOUS ENUE 13. FATHER'S NAME MOTHER'S MAIDEN NAME INFORMANT Address WAS DECEASED EVER IN U.S. ARMED FORCES? 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the buriol-tronsit p ONSET AND DEATH PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate couse (o), DUE TO stating the underlying cause has been ije Health prior to PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPS)
PERFORMED? USe YES T NO I O FUNERAL DIRECTOR: After this certificate ق 205 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.) 200 ACCIDENT WAS UNDERLYING [1] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (State) TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (County) Hour am. Not While factory, street, office bldg., etc.) ot wark at wark 21. I certify that (1) (this haspital) attended the deceased fram. , 19 67, ta Mar 30, 1962, that (1) (we) last many be retained 1967, and that death occurred at 1 4 M, fram causes and an the date stated above saw the deceased alive an 22b. DATE SIGNED 220 SIGNATURE ATTENDING PHYS. DIRECTOR PHYS. M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) CHIN should director, 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a BURIAL, CREMATION, DATE THEREOF (County) (Stote) REMOVAL (Specify) 24.2 FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 1967





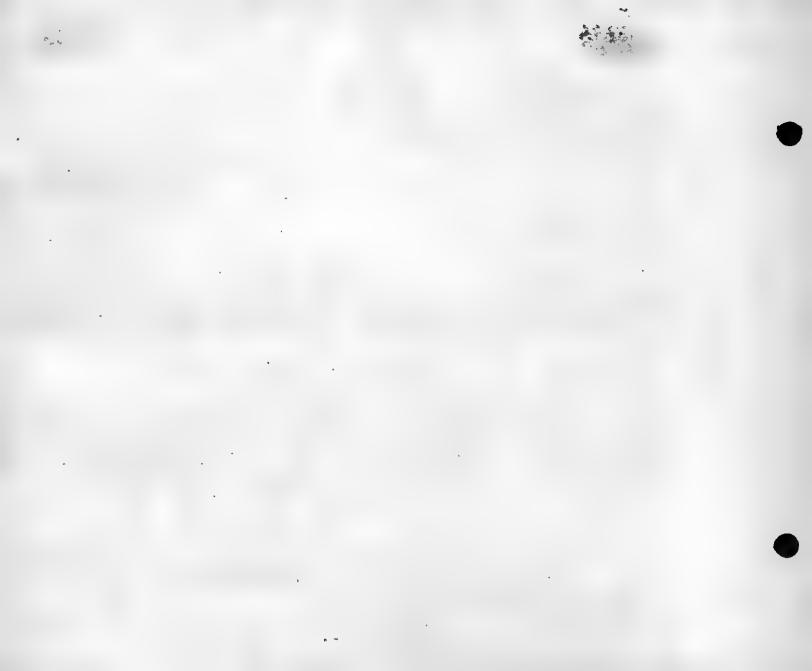
	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
i alien	03432 Thems #8 & CERTIFICATE OF DEATH 03427
一事 咖啡	1. PLACE OF DEATH a. COUNTY b. COUNTY c. STATE b. COUNTY
Take if	MARYLAND a. STATE b. COUNTY Carry le
- 60	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
in Pa	Westmenster (Reval) */ PRS. Westmenster RED 4 (Reval)
fille m 72	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? YES 1 NO
I within pletely garbon print, within	3. NAME OF DECEASED (Type or print) A ICE Gerfrude Eyler DEATH MArch 29 1967
executed within and completely remove carbon france carbon frank with	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 14 PROPER 1/19/19/19/19/19/19/19/19/19/19/19/19/19
	10a. USUAL DCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR II. BIRTHPLACE (County & State, or foreign country) 11c. CITIZEN OF WHAT COUNTRY2
tificate ng phys noval, i	13. FATHER'S NAME Wike Summa H. AUTS
ne death certificate be e the attending physician it permit. Then please nation, or removal, and ib	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) 2/6-22-7622
requires that the ding physician. Deen signed by the burial-trans or to burial, ore	18. CAUSE OF DEATH LEnter only one cause per line for (a), (b), and (c). T PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (c)
CIAN: The law ospital or atten certificate has ned for use as to of Health price.	
	PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES NO CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) While at work at wor
OR ATTENION OF THE NITE OF THE NITE OF THE NITE OF THE OF	21. I certify that (I) (this hospital) attended the deceased from authorized to March 29, 1967, that (II)(we) lass saw the deceased alive on 3/25 1967, and that death occurred at 4 PM, from the causes and on the date stated above 22a. SIGNATURE M.D. ATTENDING MED. STAFF 22b. DATE SIGNED ATTENDING MED. STAFF PHYS. 3/30/67
O HOSPITAL Page 4 mai O FUNERAL director, pa	22c. PHYSICIAN'S NAME (Type) W. H. FOATA M.D. 22d. ADDRESS NAME (Type) W. H. FOATA M.D. 22d. ADDRESS
TO HI Pag TO Fu	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) SUPLAL (Specify) 4/1/67 Century Pural Wathursten M. 24. FUNERAL DIRECTOR ADDRESS 125c. REC'D BY REGISTRAR'S SIGNATURE
VR A15 (4)	J. 2. myere J., Westminster, md. DAAPR 3 1967 geliarles Judge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution, Residence before odmission) 2, and 3 to PM3. Page o. COUNTY " Carroll MARYLAND Carroll Maryland b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and a ve nearest town) write RURAL and give nearest town) Rural - Sykesville State Depart d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS e IS RES DENCE along with farm ON A FARM? Rt. 10akland Road Liberty Dam YES NO TO n Item 18. Give Pages haurs after death NAME OF First Middle Lost DATE Month Day DECEASED DF (Type or pnnt) GLORIA FAGGELLT DEATH March S SEX FUNDER | YEAR IF UNDER 24 HRS 6 COLOR OR RACE B. DATE OF BRITH 9 AGE (In years 7. MARRIED NEVER MARRIED lost birthdoy) Months Auc. 02,1933 White DEVORCED [Female WIDOWED e, writing the ward "pending" in pencl in Item 11 forwarded to the Chef Medical Examiner's Office within 72 hours after deal 12 CITIZEN OF WHAT COUNTRY? 11 BIRTHPLACE (State or foreign country) 100 JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR during most of working life, even if ret red) MINISTRY Baltimore e pages 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Joseph Fusco Maria Neubauer IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) Mr. Jony Paraelli Same As #2 18. CAUSE OF DEATH (Enter on y one couse per line for (o), (b), and (c)) INTERVAL BETWEEN burial-transit event v PART I. DEATH WAS CAUSED BY. ONSET AND DEATH Asphyxia IMMEDIATE CAUSE (o) This cert ficate should DUE TO any Conditions, if any, which gove Drowning. rise to immediate couse (a), DUE TO stoting the underlying couse 19 WAS ALTOPS) remayal, PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) PERFORMED? the certificate, YES X NO should be 20o EXTERNAL CAUSE WAS 206 DESCRIBE HOW INJURY OCCURRED (Enter noture of mury in Port Lior Port Liof Item 18) 3 shauld PRIMARY XI or CONTRIBUTING [Threw self into Dam. CAUSE OF DEATH. MEDICAL 20c. TIME OF NLLRY Month, Day, Year 20d NJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) (State) foctory, street, office bldg., etc.) Hour o.m. Not While While DIRECTOR: Page of work of work Carroll Md. 3/19 19 67 21 | Certify that I took charge of the remains described above, held an Autopsy | | Inspection Inquiry and in my apinion Natural causes | | the funeral director. death resulted from. Akcident Suicide X Hamicide [Undetermined manner be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER FUNERAL D pridr SIGNATURE DEPLTY MEDICAL EXAMINER 3/20/67 **EXAMINER'S** 5 may FO FUNE Health NAME (Type) Address (Street, city, town, or county) Charles S. Patty 23c NAME OF CEMETERY OR CREMATORY 230 BUR, AL CREMATION 23b DATE THEREOF 23d LOCATION (City or Town) (County) REMOVAL (Specify) Lakeview Merorial Gardens Carroll. 2So. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15ME (5) Sukerville, id. 6M 1/67



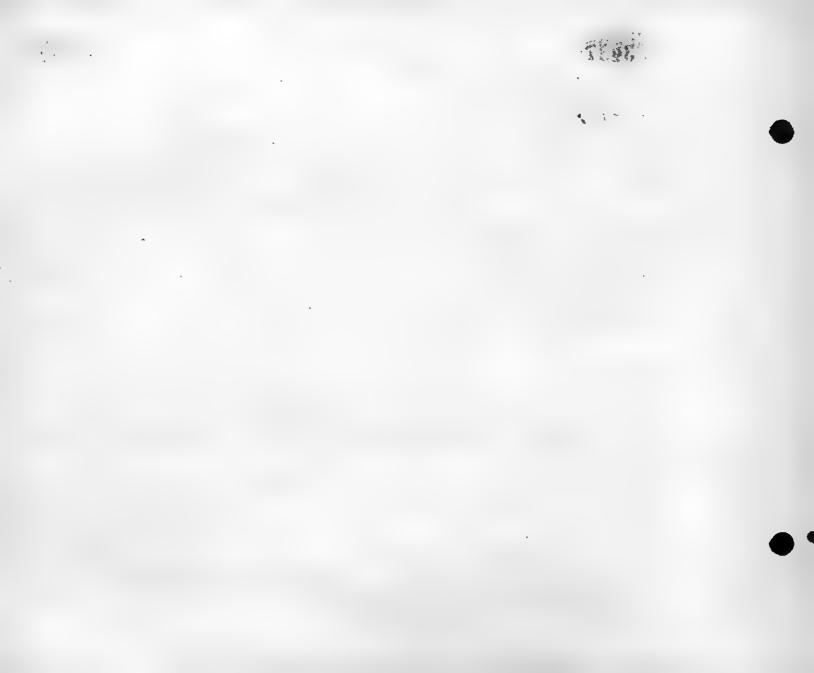
21	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03428
HEALTH DEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
	a. COUNTY BROLL COUNTY MARYLAND B. COUNTY BARROLL
essary, funeral nay be rrment death.	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
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cessary, o the funeral e 5 may be Department after death.	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 6. IS RESIDENCE ON A FARM?
delay nd 3 to Page State hours	RT #5 SALEM BOTTOM ROAD RT#5 SALEM BOTTOM RA YES NOW
after death. If any delay is give Pages 1, 2, and 3 to ong with form PM3. Page is 1 and 2 with the State is any event within 72 hours a	3. NAME OF First Middle Last 4. DATE Month Day Year DECEASED 61 APA 6 TO THE 61 APA 6 TO THE DECEASED 61 APA 6 TO THE DEC
any C 2, ar PM3.	(Type or print) KARN EUGENE PRINT DEATH MARGIE 17 MARRIED NO. 8. DATE OF BIRTH 9. AGE (ID. years IF UNDER 14 EAR IF
ith. If an form P form P within	1 And 1 Markites Markites 1943 1945 Months Days Hours Min.
with f	106. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLAGE (State or foreign country) 12. CITIZEN OF WHAT
1 all all every	during most of working life, even if retired) INDUSTRY LIRAN IST CLASS. U.S. A INFORCE - DEFENSE CARROLL COUNTY AD. U.S.A.
	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
	RUSSELL WILLIAM FREYMAN RUTH LOUISE LITTLE
n 24 hou in Item office office i. File p	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFURMANT Address ATE 5. (Yes, po, or unknown) ((1) yes give war or dates of service) 7 15-37-7/77 (2) 15-37-77 (2) 15-37-77 (2) 15-37-77 (2) 15-37-77 (2) 15-37-77 (2) 15-37-77 (2) 15-37-77 (2) 15-37-77
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be executed within pending in pending in pendil in Medical Examiner's urial-transit permit.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I, DEATH WAS CAUSED BY: THE TANK BELLY INTERNAL SELLY INTERN
Existing 1, or an exist of the control of the contr	- 21 IMMEDIATE CAUSE (a) / CENTRAL CAUSE (b)
I'd be executed I "pending" in if Medical Exan is burial-transit cremation, or	Conditions, If any, which (b) Constitutions Upper Chart
Me.	gave rise to immediate cause (a), stating the DUE TO
should word ' Chief as a t nial, c	underlying cause last. (c) Was autopsy
certificate should be titing the word "per ded to the Chief Med Id be used as a buria prior to burial, crem	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO NO 20a. EXTERNAL CAUSE WAS PRIMARY OF OF CONTRIBUTING CAUSE OF DEATH. 210. DESCRIBE HOW INHURY OCCURRED. (Enternature of Injury In Part 1 or Part 11 of Item 18) CAUSE OF DEATH.
iffica to the e us	2Da. EXTERNAL CAUSE WAS 2Db. DESCRIBE HOW INCURY OCCURRED. (Epter, nature of injury in Part or Part of Item 184)
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ER: cate	20c. TIME OF INJURY Month, Day, Year 20d. MJURY OctuRAED 206. PLACE OF INJURY Home, Tarm, Concentration of Stare) 3. Hour am. 3-2 1967 at work Not While at work of Court 47
AEDICAL EXAMINER: cute the certificate age 4 should be fo r your files. DIRECTOR: Page 3 or its designated ag	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection Z, Inquiry, and In my opinion
EXA ne ce shoul files. for:	death resulted from: Natural-causes , Accident , Suicide , Homlolde , Undetermined manner
(3 7 7 7 7	ACTUAL ACTUAL ASSISTANT MEDICAL EXAMINER 22. BATE SIGNED
ry MEDIC execute Page 4 1 for you RAL DIRE	ACTUAL SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER OFPUTY MEDICAL EXAMINER TO THE SIGNED
	EXAMINER'S W. GLENN ISPEICHER Address Street, in demander on country I have after
O DEPUTY M please exec director. Pr retained for o Funeral. of Health o	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)
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مرابع الح	E24		03435 CERTIFICATE OF DEATH	03429
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Pol .	filled in papers. I		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE DN A FARM?
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that the death certificate be executed within sician.	E 2 2	(Y	S. WAS DECEASED EVER IN U.S. ARMEO FORCES? 16. SDCIAL SECURITY NO. 17. INFORMANT Address st, no, or unknown) (If yes give war or dates of service) 2/3-0/-606 MARCARFT FURRY UNION	RRIDGE
je de	the lit pe nation	-	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN DNSEV AND DEATH
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law r	has been as the prior to	NO	underlying cause last.) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	1(a) 19. WAS AUTOPSY
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PHYSICIAN: the hospital	After this cert i be detached State Dept. of		20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 1 20f. (City or town)	(County) (State)
25 yo	After t d be de State	MEDICAL	Hour a.m. While Not While factory, street, office bldg., etc.)	
ATTENDIN			21. I certify that (I) (this hospital) attended the deceased from 1959, to 3 16/67, 1	
ATT	S shoul with th		saw the deceased alive or 3/16/67 19 , and that death occurred at 75 M, from the causes and (22a. SICNATURE A	
L OR	Page page filed		M.O. PHYS. MEO. DIRECTOR PHYS.	3 16 67
HOSPITAL	25 - 20		22C. PHTSCIAN'S NAME (Type) J H CARICOFF IINION BRIDGE D	71)
TO HOSP	O FUNERA director, should be	23	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LDGATION (City, town of REMOVAL (Specify)	r county) (State)
Ħ	5 0	24	BURIAL 3/19/67 PIPE CREEK CARRELL CO	RAR'S SIGNATURE
VR	A15 (4)		DD Hartsler & Sono Umon Bridge Mod DATMAR 20 1967 Ocho	rlas Inder
20N		-		7 1

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF death. requires that the death certificate be executed within 24 haurs after death lond 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH a. COUNTY b CITY OR TOWN (If autside corparate limits, c. LENGTH OF STAY IN 16 write RURAL and give nearest town) ESTMINSTE d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE 3 NAME OF Eirst 4 DATE Month Day DECEASED MARGIE MARZCH (Type or print) 5 SEX 6. COLOR OR RACE B DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED pleose remove last birthday) 10b. KIND OF BUSINESS OR 10a USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHA? 1) BIRTHPLACE (County & State, or foreign country) during most of working I te, even if retired) **COUNTRY** CARRULL 14 MOTHER'S MAIDEN NAME 15 FATHER 5 NAME 17. INFORMANT 16. SOCIAL SECURITY NO (Yes, no ar unknown) (If yes give war or dates of service) 112 GONI, TER, WESTHINSTER 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) burial-tronsit PART I. DEATH WAS CAUSED BY: MYOCARDIAL INFARCTION IMMEDIATE CAUSE (o) DHE TO Conditions if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been the 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) YES IN NO 20g ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm 20f. (City or town) (Caunty) (State) 20c. TIME OF INJURY Month, Day, Year Haur o.m. factory, street, affice bldg., etc.) Not While 2). I certify that (1) (this haspital) attended the deceased from 3-10- , 1967, ta 3-24-, 1967, that (1) (we) last 19 67, and that death accurred at 3 20 M, from causes and on the date stated above. 3-24saw the deceased alive an_ 22a. SIGNATURE 22b. DATE SIGNED MED. DIRECTOR × M.D. ADDRESS 4 BOX 41 B 22c. PHYSICIAN S HANS NIPKOW in WESTUINSTER UIF NAME (Type) director, should 23o. BURIAL, CREMATION DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) REMOXAL (Specify) FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66



ή ν	Division of STATISTICAL		PARTMENT OF HEALTH _W. PRESTON STREET, BALTIN	MORE, MARYLAND 21201	
	03437 Item #2	RESEARCH AND RECORDS, 301	OF DEATH	n	3431
funeral funeral for fer feath	PLACE OF DEATH a. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Where decease o. STATE Maryland	b. COUNTY Monte	z.,
hours aftern by the 1s. Pages hours after	b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville,	3 yrs. 1 mo.	c CITY OR TOWN (If outside corporate Olney	e limits, write RURAL and give ne	orest town)
filled in papers.	d. NAME OF HOSPITAL OR INSTITUTION (If not in ho Springfield State Hosp	, , ,	d. STREET ADDRESS Brook Grove Foun	Home. dation Nursing	e is residence on a farm? YES NO
campletely from campletely from y event, with	3 NAME OF First DECEASED (Type or print) Edith	Middle M⊕	GIBBON 4. DATE OF DEATH	Month March	3, 1967
execute d camp emove any eve	female white WID	OWED DIVORCED	DATE OF BIRTH 9 12-27-1883	AGE (in years IF UNDER I YE last birthdoy) Manths Do	γs Hours Min.
physician and campletely filled in the physician and campletely filled in the please remove carban papers. (aval, and in any event, within 72 has	100 USUAL OCCLPATION (Give kind of work done during most of working life, even fretired) Artist & clothes designs 13. FATHER'S NAME	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & Stote, or form Maine 14. MOTHER'S MAIDEN NAME	eign country) 12 CITIZE COUNT U	N OF WHAT RY? 5.A.
eath certific ending phys nit. Then p ar remaval,	Alfred Gibbon	16. SOCIAL SECURITY NO. 17	Mildred Witham	Address	
at the death cer the attending p nsit permit. The	15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	220 <u>-54</u> -6005 Sp	ringfield State H		NTERVAL BETWEEN
that th in. by the ransit p	IMMEDIATE CAUSE (0)	Arteriosclerotic	Heart Disease		ONSET AND DEATH
Page 4 may be retained by the hospital ar attending physician. To Hospital or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the hospital ar attending physician and campletely filled in by the funeral director, page 3 should be detacted for use as the burial-transit permit. Then please remove carban papers. Pages 1 or 0.2 should be filled with the State Dept. at Health priar ta burial, cremation, ar remayal, and in any event, within 72 haurs after facults.	Conditions, if ony, which gove rise to immediate couse (a), stating the underlying couse (c)	Generalazed Arter	iosclerosis		Years
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DING PHYSIC by the hospii (fler this certi be detached State Dept. af	20c. TiME OF INJURY Month, Doy, Yeor Hour o.m. 19	While of work of work of work	E OF INJURY (Home, form, 20f. ary, street, office bldg., etc.)	(City or town) (County	, , , , ,
L OR ATTENDING y be retained by th DIRECTOR: After th age 3 should be de filed with the State	21. I certify that (I) (this haspitol) saw the deceased alive on 3=	attended the deceased from, and that	1–22–64 , 19 to death accurred at 5:30 m	from causes and an the	
L OR A be rett DIRECT gge 3 sh	20 PHYSICIAN'S	galin	THIS - DIRECTOR	STAFF EX 3 DAYE	
ro Hospital ol Page 4 may be to Funeral Dir director, page should be filed	NAME(Type) Antonius G	23c NAME OF CEMETERY OR	Sykesvi	lle, Maryland	2178L unty) (State)
Page Page TO FU direc	BREMOVAL (Specify) 23 DATE HEREOF REMOVAL (Specify) 3-8-67 24 FUNGRAL DIRECTOR	South Side	0 to C1.	wheath 1	MAINE_
VR A15 (4) 20 M 1/66	Harry YV. Hoight	Sylasville. Ti	DATEMAR 7	1967 Mclianle	

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, # institution: Residence before admission) a. COUNTY b. COUNTY **MARYLAND** b. CITY OR TOWN (if outside corporate limits, write BURAL and glvg nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b I completely filled in by to ove carbon papers. Page y event, within 72 hours a Rural-Mt. Airy 6 Months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? R.D. NO X YES The law requires that the death certificate be executed within NAME OF 3. Last DATE DECEASED (Type or print) DEATH 6. COLOR OR RACE AGE (th years | IF UNDER 1 YEAR IF UNDER 24 HRS and cor remove any eve DATE OF BIRTH 7. MARRIED NEVER MARRIED 8. last Olytoday) | Months | Days Hours WIDOWED DIVORCED [10a. USUAL OCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? lousevife U.S.A. Carroll Co. . Md. attending phy ermit. Then p in, or removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Harry E. Kidd Sarah ed by the attent transit permit. , cremation, or re 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address (Yes, no, or unkown) (If yes give war or dates of service) Mr. William Mi 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b); and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: attending physician. IMMEDIATE CAUSE (a) been State the burial-tra signed **DUE TO** Conditions, If any, which gave rise to Immediate DUE TO cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY for use Health I PERFORMED? NO I YES [the hospital PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING ON CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) at work Not While factory, street, office bldg., etc.) Hour a.m. p.m. D 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at Mr. from the causes and on the date stated above. saw the deceased alive on asked 22a. SGNATURE O FUNERAL DIRE director, page should be filed v ATTENDING PHYS. MED. STAFF PHYS. O HOSPITAL HYSICIAN'S NAME (Type) 22d. ADDRES 23b. DATE THEREOF NAME OF CEMETERY OR SHEE LOCATION (City, town or county) (State) BURIAL CREMATION. REMOVAL (Specify) Mt. Ainer MA. Pine Grove PR 4 1967 PREGISTRAR'S SIGNATURE **FUNERAL DIRECTOR** ADDRESS Charles unlas VR A15 (4) 20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03439 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs ofter death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND completely filled in by the c LENGTH OF STAY IN 16 outside corporate limits CITY OR TOWN outside corporate limits, write RURAL and give nearest town) INSTITUTION (If not in hospital, give street address d STREET ADDRESS ON A FARM? NO YES. carban NAME OF Middle 4. DATE Month event, wit Lost Dov Year DECEASED OF (Type or print) DEATH s SEX AGE (In years IF UNDER UNDER 24 HRS DATE OF BIRTH NEVER MARRIED remove birthdoy) lgst Months Doys Hours in any WIDOWED DIVORCED the attending physician and sit permit. Then please rem 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working life, even if retired **INDUSTRY** COUNTRY? みアソレカ外) SHOVEL OPERH 13. FATHER'S NAME ar remayal, TS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16, SOCIAL SECURITY NO INFORMANT (Yes, no, or unknown) [(If yes give wor or dates of service) UNION BRIDGE 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) PART). DEATH WAS CAUSED BY INTERVAL BETWEEN burial-transit ONSET AND DEATH IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if any, which gave rise to immediate couse (a). DUE TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? Health NO J YES [for 200 ACC DENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) by the haspital OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dc. TIME OF INJURY Month, Day Year 2Dd. INJURY OCCURRED 2De PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour om. Not While foctory, street, office bldg., etc.) ot work 21. I certify that (I) (this haspital) attended the deceased fram. _____, 19<u>4</u> 7, that (I) (we) last 1967, to man 4 and that death accurred at 4.5 M, fram causes and an the date stated above. 1967 saw the deceased alive an many 22o. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S Page 4 may 8 ano NAME (Type) director, shauld 23b DATE THEREOL 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) BURIAL, CREMATION (Stote) VR A15 (4) 196 20 M 1/66 DATE

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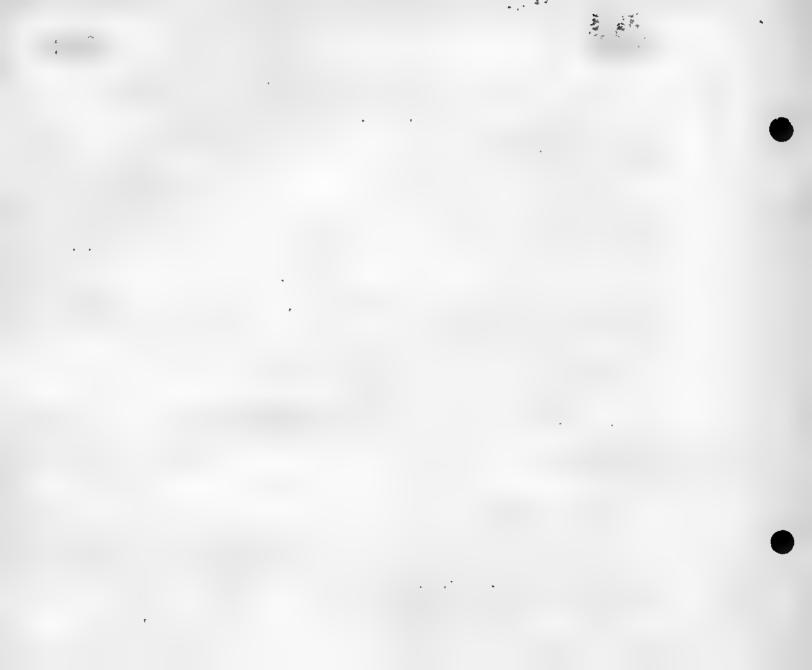
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- To D	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMO CERTIFICATE OF DEATH	03434				
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e death tending r en please l, and in	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECKASED EVER IN U.S., ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT AGGISS					
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3 should the State D	saw the deceased alive on. 112.1.2.1.19, (a7., and that death occurred at At. M., from the causes a 22a. SIGNATURE M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS.					
HOSPITAL	PHYSICIAN'S NAME (TYPE) SEM & BUSH MIL HAMPI Lind. Mys	Or or county) (Slate)				
O O O O O O O O O O O O O O O O O O O	236. NAME OF CEMETERY OR CREMATION, 236. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, low REMOVAL (Specify) arch 25, 1967 Mt. Carmel Cemetery Parkton, Md. 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REC					
15M 7-62	Tipton - Eline Funeral Home Hampstead, Md. MAR 2 3 1967	carles Judge.				



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o STATE P CONIA MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FINKCBIRG ESTMINSTER e. IS RESIDENCE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? YES 🗔 NO Z requires that the death certificate be executed within NAME OF Middle 4. DATE Year Month DECEASED OF (Type or print) DEATH SEX IF UNDER 1 YEAR JE UNDER 24 HRS. A COLOR OR RACE 7. MARRIED DATE OF BIRTH 9. AGE (In years birthdoy) Months DIVORCED 100 USUA, OCCUPATION (Grye kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) SELF COUNTRY? INDUSTRY CARRULL CA MD FARMER AND GA EMPLOYE CHARLES AUGUST 16 SOCIAL SECURITY NO. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) 2/2-20-7248A MR. FRANCIS R. HANSE buriol, cremotian, 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) signed by the buriol-transit PART I. DEATH WAS CAUSED BY. BRONGHE ZIVELMENINA IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stating the underlying cause **DIRECTOR:** After this certificate has been the lost. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) NO L 3FBKHL UMSCLEITIE. YES [INSLFFICILIZEV for 205 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item/18.) 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (State) 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED (County) factory, street, office bldg., etc.) Not While 2). I certify that (1) (this haspital) attended the deceased fram, 1967 to 19 **62**, that (1) (we) last 1967, and that death occurred at 627 M, from causes and on the date stated above. sow the deceased alive on 22b. DATE SIGNED 220_SIGRATURE ATTENDING Lucian M.D. PHYS DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S Poge 4 moy O FUNERAL NAME (Type) director, BURIAL, CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) REMOVAL (Specify) REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR FUNERAL DIRECTOR VR A15 (4) 20 M 1/66





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 24 hours after deoth PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) g COUNTY a. STATE b COUNTY after MARYLAND b CITY OR TOWN (If outside carparate limits, c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) c LENGTH OF STAY IN 1h write RURAL and give nearest town) YEARS Finksburg IS RESIDENCE ON A FARM? papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS filled YES 🗔 NO X 3. NAME OF remove carbon First Last DATE Day Year complètely DECEASED Willie Heater 1967 DEATH low requires that the death certificate be executed IF UNDER 1 YEAR 5 SEX DATE OF BIRTH AGE (In years IF JNDER 24 HRS. 6 COLOR OR RACE 7 MARRIED **NEVER MARRIED** last b rthday) Manths Days Hours gny WIDOWED signed by the ottending physician and buriol-transit permit. Then please rem KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT OCCUPATION (Give kind of work done 106 ond in during mast afwarking life, even if retired) INDUSTRY LADOTER 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME removo WAS DECEASED EVER IN U.S. ARMED FORCES 16 SOCIAL SECURITY NO 17. INFORMANI (Yes, ng, prunknawn) (If yes give war ar dates of service) Ö cremation. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gave rise to immediate cause (a), DUE TO as the prior to t stating the underlying cause ottending has been last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO E by the hospital or this certificate jo 205 DESCRIBE HOW INJURY OCCURRED. (Enter-nature of injury in Part I or Part II of item 18.) 20g. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 2 20e. PLACE OF INJURY (Hame, form, (City or town) (State) 20c. TIME OF INJURY Month, Day, Yes Haur a.m. Not While factory, street, affice blog., etc.) at work at wark TO FUNERAL DIRECTOR: After 21. I certify that (I) (this hospital) attended the decreased from Poge 4 may be retained plnous saw the deceased alive anand that death accurred at M. from causes and on the date stated above. 22a. SIGNATUR 22b. **DATE SIGNED** ATTENDING M.D. DIRECTOR AME (Type director, pluods 23a. BURLAL, CREMATION, DATE THEREOF 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) 2So. REC D BY REGISTRAR S SIGNATURE FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE DE DEATH Pages 1 and urs after dea USUAL RESIDENCE (Where deceased lived, If Institution: Residence hefore admission) a. COUNTY a. STATE b. COUNTY after MARYLAND APPINII CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b overt, within 72 hours 100LLS .5 VESTANIASTER d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADORESS e. IS RESIDENCE ON A FARM? 182 WASHINGTON NO ! YES completely Month DECEASED (Type or print) DEATH and in any ove 5. SEX DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIEO NEVER MARRIEO last birthday) Months Hours WIOOWEO OIVORCED T 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, ■ foreign country) physician that the death certificate be COUNTRY? IN CLOTH removal, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY ND. certificate has been signed by the attended for use as the burial-transit permit. (Yes, no. or unknwn) \((If yes give war or dates of service) INTERVAL BETWEEN 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] ONSET AND GEATH PART I. CEATH WAS CAUSED BY: 3 mas the hospital or attending physician. IMMEDIATE CAUSE (a). OUE TO Conditions, If any, which gave rise to immediate as the prior to DUE TO cause (a), stating underlying cause last. WAS AUTDPSY CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO PERFORMEO? YES NO Z 208. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) OESCRIBE HOW INJURY OCCURRED, (Enter nature of intury in Part 1 or Part II of Item 18.) State Dept. should be designed MEDICAL (State) 20d, INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm.) TIME OF INJURY Month, Day, Year 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. Not While be retained by at work 21. I certify that (I) (this hospital) attended the deceased from 600.24 1964 to Main 24 Page 4 may be retained FUNERAL DIRECTOR: 1947, and that death occurred at 335 M, from the causes and on the date stated above. saw the deceased alive on There 22b. OATE SIGNEO 22a. SIGNATURE director, page should be filed ATTENOING PHYS. DIRECTOR PHYSICIAN'S ADORES: 22c. NAME (Type) BURIAL, CREMATION, LOCATION (City, town or county) REMOVAL (Specify) REC'O BY REGISTRAR FUNERAL OIRECTOR VR A15 (4) 15M 4-64



COUNTRY? Address INTERVAL BETWEEN ONSET AND DEATH 5 2 WAS AUTOPSY PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM INAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO 🖂 YES 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in/Part I or Part II of Item 18.) (State) (County) M, from the causes and on the date stated above. 22b. DATE BURIAL, CREMATION, REMOVAL (Specify) BUTIAL LOCATION (City, town or county) (State /17/67 St. Peter's Cemetery Hampstead. Md. ADDR ESS REC'D BY REGISTRAR I 25b. REGISTRAR'S SIGNATURE **FUNERAL DIRECTOR** Tipton - Eline Funeral Home Hampstead, Md.

e. IS RESIDENCE

Day

12. CITIZEN OF WHAT

ON A FARM? YES NO

Year

19

15M 4-64

VR A15 (4)



			DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND					
म् वृष्ट			U3446 CERTIFICATE OF DEATH	3448				
fune fune shou	_ 1		PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Reside 3. COUNTY 3. STATE 4. COUNTY	nce before admission)				
04.3 1.2.1	9		MARYLAND Med Carroll.					
by and		\	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	nearest town)				
E Se 1			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	<i>j</i>				
Page Vi	111	Ψ.		IS RESIDENCE ON A FARM?				
stely sers. 2 ho		3. 1	NAME OF First Middle (Last , 4. DATE Month De)	YES -HO T				
nple pap	M)		DECEASED William H. Heffman DEATH March 6	1967				
S S S S S S S S S S S S S S S S S S S	# /	5. 5	SEX / 6. COLOR OR RACE 7, MARRIED NEVER MARRIED 8 DATE OF BIRTH 9. AGE (In years IF UNDER LYEA)					
and and cart			Hall WIDOWED DIVORCED 72718, 1880 Sast birthday Months Days	Hours Min.				
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certi hysi rem any			James (unoll Co. 43	4				
ath page agase rin		13.	FATHER'S NAME					
d jage		18	William S. And South States of the same of					
There are		(Yes	WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMATION Address 220, no. or unknown) ((flyesgiva warordetas of service) 220 44 6780.1	. A las C				
that n. the iii.		-	Congetty The	TERVAL BETWEEN				
sicia Sicia I by		11	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thy grander try mines	NSET AND DEATH				
phy phy gnex isit (DUE TO	ince				
ling in si			Conditions, if any, which ? (b) & generalized authorized	3 yes				
he lend tend tend tend tend tend tend tend t			gave rise to immediate cause (a), stating the underlying DUE TO	4				
A: I			causa last. (c)					
tal cate	0	OF N	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART ((a)	19. WAS AUTOPSY PERFORMED?				
SIC losp ertifi use rior	.1	15	20s. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of item 18.)	YES NO				
PHY he had a single of the for		 	20b. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part II of itam 18.) OR CONTRIBUTING CAUSE OF DEATH OF EITHER, NOTIFY MEDICAL EXAMINER)					
by the		1 . !	20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County)	(State)				
Ted Africa		MEDICAL	Hour e.m. While Not While fectory, street, office bldg., etc.)					
TEN OF TEN		I ~ ⊩	21. I certify that (1) (this hospital) attended the deceased from Nov 12 , 1966 to A worth, 1967	that (1) (we) las				
14の記号画		1 1	saw the deceased alive on A and 5 1967, and that death occurred at 20 M, from the causes and on the da					
4 ±			22e. SIGNATURE ATTENDING MED. STAFF	226. DATE SIGNED				
AL PAR			M.D. PHYS. DIRECTOR PHYS. 3/6	167				
Paginer, page of, page of with			22c. PHYSICIAN'S NAME (Type) WIFFORT MD. SiANIGESTET M.	1				
death. O PU	1 P	230.	BENDAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (CVY, town or county) REMOVAL Specify: 3/9/67 Niddle TOWN CMETERY Free and	Md (State)				
VR A15	101	24	FUNDRAL DIRECTOR'S SIGNATURE 256. REGISTRAR'S SIGNATURE 256. REGISTRAR'S SIGNA	ATURE				
15M 7-6		5	L. Jacob Harlenston How Freedom Ja MAN 8 1967 Juliantes &	noge.				
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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE. MARYLAND 21201 CERTIFICATE OF DEATH 03447 Acompletely filled in by the funeral maye carbon papers. Pages 1 and 2 ny event, within 72 hours after death. 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY b. COUNTY n. STATE Carroll Maryland MARYLAND requires that the death certificate be executed within 24 hours ofter b CITY OR TOWN (If autside carparate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside comparate limits, write RURAL and give negrest town) write RURAL and give nearest town)

Sykesville ./8 mos. 21230 Paltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS B IS RESIDENCE ON A FARM? Springfield State Hospital 701 E. Fort Avenue YES NO SC 4 DATE OF 3 NAME OF Middle last Month Day Year DECEASED (Type or print) Christopher HOIMES George 1967 DEATH March IF UNDER 24 HRS. B. DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR S SEX 6 COLOR OR RACE NEVER MARRIED 7. MARRIED last birthday) Months Dovs Hours 12-11-1887 white WIDOWED DIVORCED male the attending physician and sit permit. Then please remoted notion, or removal, and in an 10a USUA OCCUPAT ON (Give kind of work door during most of working life even fretired)
Watchman-Chief Bridge 11. BIRTHPLACE (County & State, or fareign country) 10b. KIND OF BUSINESS OR 12 CIT-ZEN OF WHAT COUNTRY? INDUSTRY Maryland 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Katie Eisenhart - dec. Jacob Holmes - dec. 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, na, or unknown) (If yes give war or dates of service Springfield State Hospital R.cords no INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the buriol-transit p buriol, cremotic PART ! DEATH WAS CAUSED BY ONSET AND DEATH Arteriosclerotic heart disease. Yrs. IMMEDIATE CAUSE (o) physician. DHE TO Generalized arteriosclerosis. Conditions, if any, which gove ? vrs. rise to immediate cause (a), DUE TO stoting the underlying couse Page 4 may be retained by the hospital or attending TO FUNERAL DIRECTOR: After this certificate has been os the WAS AUTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) far use NO Ex CBS with cerebral arteriosclerosis with psychotic reaction. 20b, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18.) 20g ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (State) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (County) 20c. TIME OF INJURY Manth, Day, Year Not While factary, street, office bldg, etc.) of work of work 21. I certify that (f) (this haspital) attended the deceased from 7-10-61 saw the deceased glive an 3-26-67 19 and that death accurate 3-26-67 , 19___, that (I) (we) last . 19 and that death accurred at 2:30M, fram causes and an the date stated above saw the deceased alive an_ 22b. DATE SIGNED 22a. SIGNATURE ATTENDING MED. DIRECTOR STAFF PHYS. **G** 3-26-67 22d, ADDRESS Springfield State Hospital 22c PHYSICIAN'S NAME (Type) Antonius Glakn, M.D. Sykesville. Maryland director, p 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b. DATE THEREOF (County) (State) 23a BURIAL, CREMATION, REMOVAL (Specify) Cedar Hill Cemetery Ritchie Hgwy. A.A.Co., Md. 3-30-1967 2Sa. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR Charles VR A15 (4) 20 M 1/66 DATMAR 28 George J. Gonce-4001 Ritchie Hgwy., Baltimore 1967



1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND					
FOR STATE	03448 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	3442				
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if institution: R a. STATE b. COUNTY Maryland Maryland					
delay is necessary and 3 to the funeral page 5 mat fill state bepartment hours after death	b. CITY OR TOWN (if outside corporate limits, write RURAL write RURAL and give nearest town) Sykesville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	end give nearest town)				
y is right age 5 age 5 age 5 are De ate De ate De are aft	Springfield State Hespital, Sykesville 4516 Umatilla Avenue	ON A FARM?				
M3 1 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1	3. NAME OF First Middle Last 4. DATE Month OF	Oay Year 19 67				
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years FUNDER Months Widowed 2-10-19 48 vrs.	1 YEAR IF UNDER 24 HRS. Days Hours Min.				
fiter deal Give Pal B with 1 and	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Pennsylvania 12. C	ITIZEN OF WHAT OUNTRY? S.A.				
urs aft 18. G along	13. FATHER'S NAME					
them ffice file	Benjamin Cohen Julia Mae Epstein 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address					
within 24 pencil in miner's 0's permit. Fremoval, s	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes pire war or dates of service) yes 19/11-215 16. SOCIAL SECURITY NO. 17. INFORMANT Address 207-01-5182 Records, Springfield State Hospit					
ecuted with the period of the control of the contro	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).1 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction	ONSET AND DEATH				
uld be exc i "pendir ef Medica = burial-t	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	years				
nte shore word he Childhall burial		PERFORMEDI				
certifica riting the ded to the ald to the	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Manic depressive reaction, manic (hypomanic) type. 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Port 1 or Port II of Item 18 CAUSE OF DEATH.	YES NO				
NER: This (ficate, write forward) to forward le sent, id agent, it	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20f. (City or town) (Company of the pure of the p	unty) (State)				
EXAM he cert should files. TOR: Pa lesignat	21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection I, Inquiry I, death resulted from: Natural causes Accident I, Suicide I, Homicide I, Undetermined manner	and in my opinion				
MEDIC ecute Page 4 or you or jour its	ACTUAL SIGNATURE SIGNATURE DELLA M.O. ASSISTANT MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY	3-14-67				
EPUT ase ector ainec ainec	EXAMINER'S NAME (Type) W. Glenn Speicher, M.D. Addes (Street Authorities of the Control of the C	unty) Janet				
R	Bring Star (10)	'S SIGNATURE				
VR A15ME 3500 4-64	OMAK Z Z BOOT	0_0_				



		Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201						
		0344 9 ·	CERTIFICATE	OF DEATH	0	3443		
uneral	1.	o. COUNTY Carroll	MARYLAND	a. STATE	b. COUNTY	Y		
The law requires that the death certificate be executed within 24 haurs after death, attending physician. has been signed by the attending physician and campletely filled in by the funeral se as the burial-transit permit. Then please rease carbon papers. Pages + and 2 th priar to burial, cremation, or removal, and is any event, within 72 haurs differed att.		b CITY OR TOWN (If outside corporate limits write RJRAL and give nearest town) Rural Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital	c. LENGTH OF STAY IN 1b 3y 2m 27da I, give street address)	Ruxton Ri	corporate limits, write RURAL and give	e is residence ON A FARM?		
rin 24 filled pape				7011 Char.	lesridge Road 4	YES NO TO		
campletely to		DECEASED Mathew John Erne	est H	ıbin	OF March	Day Year 18 1967		
d camp		***************************************	D. TORCED	7/7/80	last pathdoy) Months yrs.	YEAR IF UNDER 24 HRS Doys Hours Min		
ian and sase regarding in diagram	10 di	00 USUAL OCCUPATION (Give kind of work dane luring most of working life, even if retired) Baker	KIND OF BUSINESS OR INDUSTRY		te, ar foreign cauntry) 12 CIT Col	IIZEN OF WHAT		
hysic of, o	CERTIFICATE OF DEATH							
e attending physic permit. Then ple tian, or remaval, o		IS WAS DECEASED EVER N. S ARMED EDROSES? 1.16	6. SOCIAL SECURITY NO 17 IN		Llard Address	-		
iften ermit n, or	L		216-05-3044 Sp.	ringfield Hos	nital records. Sy	kesville.Mi		
y the a		1B. CAUSE OF DEATH (Enter only one couse per line f PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Br	for (o), (b), and (c).)			INTERVAL BETWEEN ONSET AND DEATH		
quires the physician. signed by burial-trar burial, crei		1 10 A DUE TO	•					
attending physician. has been signed by se as the burial-tra th priar ta burial, cre		lise to fillined of couse (o), { Dife to			1	years		
been s the iar ta	ı	lost. (c)						
use a	30	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING				19. WAS AUTOPSY PERFORMED?		
for FUNERAL DIRECTOR: After this certificate has been director, page 3 should be defacthed for use as the shauld be filed with the State Dept. of Health priar to	CEPTIFICAT	Chronic Brain Syndrome, 20d. ACCIDENT WAS UNDER YING CON CONTRIBUTING CAUSE OF DEATH (ILE STUBE NOTICE WAS PROPERLY BY ANALYSE)	DESCRIBE HOW INJURY OCCURRED. (I	OSCLEPOSIS WITE Enter noture of injury in Part I	th psychotic reac	tion No 🛛		
detache le Dept.	MEDICAL	20c TIME OF INJURY Manth, Doy, Year 20d.	ile Net While facta	E OF INJURY (Home, form, ry, street, office bldg., etc.)	20f. (City or town) · (Cau	unty) (State)		
Affer be Staf		21. I certify that (this haspital) atte		12/19/63 , 19	to_3/18, 19_	67 that (4) (we) last		
CTOR: A Shauld ith the		3411 1110 40104304 61110 611		death accurred at 10				
Page 4 may be retained by the haspital ar IO FUNERAL DIRECTOR: After this certificate director, page 3 shauld be detached far u shauld be filed with the State Dept. af Heal	ı	Sula	Ozem, MD	. PHYS DIRE	CTOR PHYS. XX 3/	ATE SIGNED 18/67		
May RAL C	1	MANIC (Time)	v ·		ingileid State Ho esville Maryland			
UNE setar,	2	30 BURIAL CREMATION. 23b DATE THEREOF	23c NAME OF CEMETERY OR C			(Caunty) (State)		
dis dis		THUNG (Mady) 3/21/1967		emetery	Matthews, Virgin			
15 (4) i 1/66	2	24. FUNERAL DIRECTOR	Ballo mel	250 REC'D BY	REGISTRAR 2Sb. REGISTRAR'S SI			
J M 1/66	10	Mm. 18Man LX con-	with In.	DATE ****	ייין וייין	1		

MAKTLAND STATE DEPARTMENT OF HEALTH

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution, Residence before admission) a. COUNTY a. STATE b. COUNTY Carroll MARYLAND CITY OR TOWN III outside corporate limits, write RURAL and give necrest town b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 write RURAL and give negrest town! Finksburg, Md. Finksburg d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) a. IS RESIDENCE ON A FARM? Route 1. Seminole Lane YES NO TO papers. n 72 ho Seminole Lane **Explored** Route 1 3. NAME OF Middle DECEASED (Type or print) DEATH Pantelis 1967 March Kariotis 6. COLOR OR RACE 7. MARRIED NEVER MARRIED X 9. AGE (In years | IF UNDER I YEAR IF UNDER 24 HRS. last birthdey) Months Male White WIDOWED [DIVORCED | ease remove 10e. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY done during most of working life, even if retirad) Painter Painting U.S.A. Greece 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Peter Mary Makricostas ā 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 116. SOCIAL SECURITY NO.1 17. INFORMANT (Yes, no, or unkown) | (If yes give we rordates of service) Peter Kariotis No ending physician. been signed by the -400 Poleroft Street, Baltimore Hiteral Berte 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY, Intestinal adhesions due to carcinoma implants IMMEDIATE CAUSE (a) Carcinoma stomach Conditions, if any, which' (b)_ gave rise to immediate cause DUE TO (a), stating the underlying PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 110-11 19. WAS AUTOPSY CERTIFICATION 5 a PERFORMED? NO TY 20a. ACCIDENT WAS UNDERLYING | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of stem 18.) OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY Month, Dey, Yeer 20d. INJURY OCCURRED | 20e, PLACE OF INJURY (Home, farm, 1 20f. (City or lown) (County) (Stete) fectory, street, office bldg., atc.) Hour am While Not While at work al work p.m. to 1/28/67 19, that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from. 1.4 saw the deceased alive on... 22e. SIGNATURE 22b. DATE ATTENDING **STAFF** SIGNED PHYS. DIRECTOR death. Page 4 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) George Govatos, M.D. Medical Arts Bldg., Balto.-1, Md 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stete) REMOVAL (Specify) 3/10/67 Greek Orthodox Cemetery, Baltimore, Md. P P P Burial 24 FUNERAL DIRECTOR'S SIGNATURE 3021 Eastern Avenue Baltimore, Ind. 21224 256. REGISTRAR'S SIGNATURE

ARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH



1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND		
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TO HOSPITAL OR ATTENDING PHYSICIAN: TIm I. Page 4 may be retained by the hospital or at To FUNERAL DIRECTOR. After this certificate bedirector, page 3 should be detached for use should be filed with the State Dept. of Health	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State) While p.m. 19 at work at work		
ENDIN ined R. Af Suld R the S	21. I certify that (I) (this hospital) attended the deceased from May 18, 1964, to March 27, 1967, that (I) (we) last		
RECTO 3 sh	saw the deceased alive on Naurice 27 1967, and that death occurred at 432M, from the causes and on the date stated above. 22a. SGNATURE 22b. DATE SIGNED		
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HOSPITAL Page 4 may FUNERAL director, page	(NAME (Type) 05 8/2 & (Bush MD) HAMPSTEND Maryland		
TO H Pag TO FL dire	23a. (BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 3/24/67 Masaric Sea-Fuffers		
VD A1E (A)	24. FUNERAL DIRECTOR ADDRESS		
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DIVISION OF STATISTICAL RESEARCH AND RECORDS RESTON STREET, BALTIMORE 1, MARYLAND OF DEATH PLACE OF DEATH 2. USUAL BREIDENCE (Where deceased lived, If institution; Residence before admission a. COUNTY b. COUNTY MARYLAND 혼건 by the b. CITY OR TOWN Iff outside corporete I mits c. LENGTH OF STAY IN 16 OR TOWN (If outside corporate limits, write RURAL and g ve neerest lown) write RURAL and give neerest lown) d. STREET ADDRESS IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address ON A FARM? YES NO papers. NAME OF DATE Dey Year Middle Month DECEASED OF (Type or print) DEATH 19 and 9. AGE (In years | IF UNDER 1 YEAR | S. SEX 6. COLOR. DATE OF BIRTH IF UNDER 24 HRS. /OR RACE 8. NEVER MARRIED last birthday and Months Hours DIVORCED 164. USUAL OCCUPATION (Give kind of work BUSINESS OR INDUSTRY foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired T3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME please 16. SOCIAL SECURITY NO. WAS DECEASED EVER IN U.S. ARMED FORCES (If yes give we ror detes of service (Yes, no.cor unkown) 18. CAUSE OF DEATH (Enter only one cause per line for/(a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the underlying cause last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED 20a. ACCIDENT WAS UNDERLYING 1- 1-20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Port I or Part II or Part OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (County) 20c. TIME OF INJURY 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) Month, Dev. Yeer factory, street, office bldg., etc.) While Not While Hour a.m. at work al work 21. I certify that (I) (this hospital), attended the deceased from Max 10. , and that death occurred at 30 MM, from the causes and on the date stated above ...19.6 the deceased alive on 22b. DATE SIGNATURE 22a. ATTENDING PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type LOCATION (City, town or county BURIAL, CREMATION, | 236, DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) LAVONAL (Specify) 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE 24 PUNERAL DIRECTOR'S SIGNATURE **ADDRESS** VR A15 (4) DATE 15M 7-62

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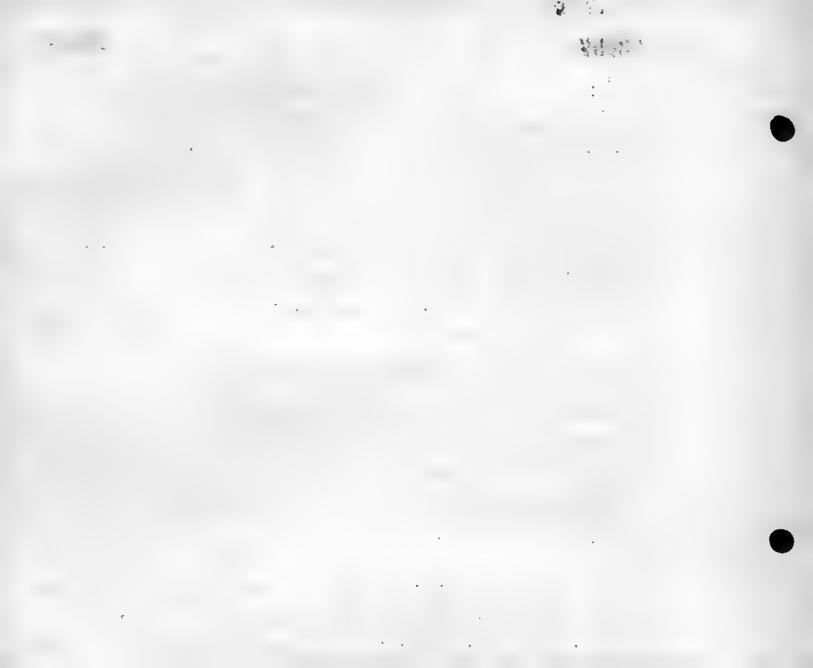
OF HEALTH



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OR ATTENDING DD RECTOR: Afte gg 3 should be ed with the St	21. I certify that (17) (this hospital) attended the deceased from - Sept , 1955, to March 19, 1957, that (17) (we) last			
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TAL may AL C	22c. Physician's NAME (Type) W 11 C 1 22d. ADDRESS			
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TO HOSPITAL OR ATTENDIPAGE 4 may be retained TO FUNERAL DIRECTOR: A director, page 3 should should be filed with the	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)			
	Bureil : 3/4/6/ Truennount Silmmount, MY - 24. FUNERAL DIRECTOR ADDRESS 1 258, REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03450 CERTIFICATE OF DEATH 03456 requires that the death certificate be executed within 24 hours after death and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) attending physicion and campletely filled in by the funeral permit. Then please removes carban papers. Pages I and on, or remayal, and in any event within 72 hours after deat o. COUNTY o. STATE b. COUNTY Carroll MARYLAND Maryland Baltimore City b (FTY OR TOWN (If outside corporate limits c CITY OR TOWN (If outside carparate limits, write RURA), and give nearest town) r LENGTH OF STAY IN 1b. write RURAL and give nearest tawn) days Sykesville Baltimore d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) IS RESIDENCE ON A FARM? d. STREET ADDRESS 2823 Pinewood Ave. Springfield State Hospital YES NO TO 4 DATE NAME OF First Middle Last Dov Year DECEASED OF DEATH CLARA MAY MAYFORT MARCH 19 67 (Type or pont) IF LINDER 1 YEAR IF UNDER 24 HRS. S SEX 6 COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED lost pirthdoy) Months Days Hours 12-26-1880 White WIDOWED X Female 10o USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR If BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) INDUSTRY Dressmaker Maryland II.S.A 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Madicai Cross Laura Petticord WAS DECEASED EVER IN U.S. ARMED FORCE S? 17. INFORMANT 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war or dates of service) Records, Springfield State Hospital Unk. cremation. INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY ONSET AND DEATH **burial-transit** Heart failure IMMEDIATE CAUSE (o) ģ 4300 DUE TO Years Arteriosclerotic heart disease Conditions, if any, which gove rise to immediate cause (a). DUE TO stoting the underlying couse as the TO FUNERAL DIRECTOR: After this certificate has been lost. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) far use YES X NO 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of Item 18.) 20g ACCIDENT WAS UNDERLYING [1] OR CONTRIBUTING I CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) Hour o.m. Not While factory, street, office bldg , etc.) Page 4 may be retained by 2) I certify that (1) (this haspital) attended the deceased from 2-17-67 19____, that (1) (we) last M. Iram causes and an the date stated abave. and that death accurred a saw the deceased alive an. 22b. DATE SIGNED SIGNATUR **ATTENDING** 3-9-67 DIRECTOR 22d ADDRESS Springfield State Hospital PHYSICIAN'S directar, po shavid be f NAME (Type) Antonius Glahn, M. D Sykesville, Maryland BUR AL, CREMATION, NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 23b DATE THEREOF Loudon Park (emetery timore, 24 FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 250 REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE VR A15 (4) 1967 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03457 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission.) o. COUNTY ? o STATE MARYLAND (If outside corporate limitsc LENGTH OF STAY IN 16 outside corparate limits Avrite RURAL and give nearest town) give necrest town carbon popers. Poc ego: within 72 hours ond completely filled in by S RESIDENCE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address d. STREET ADDRESS YES NO NAME OF DATE Month Doy Year DECEASED OF Type or print DEATH IF UNDER 1 YEAR IF JINDER 24 HRS S. SEX NEVER MARRIED AGE (In years remove' lest birthdov) Months Dovs Hours DIVORCED WIDOWED and in ony 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b KIND OF BUSINESS OR County & State, or foreign country) 12 CITIZEN OF WHAT pleose INDUSTRY COMINTRY physician 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removol, e e isigned by the offending plantial-transit permit. There buriol, cremotion, or remove IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service 16 SOCIAL SECURITY NO 17. INFORMANT Address INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (b) ond (c) PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o' physician. DUE TO Conditions, if only, which gove (b) rise to immediate couse (a). DUE TO stating the underlying couse as the hos been lost. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION NO YES 🗔 O FUNERAL DIRECTOR: After this certificate 흐 200 ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form. (City or town) (County) (State) 20c TIME OF INJURY Months, Day, Year Hour o.m foctory, street, office bldg., etc.) While Not While of work ot work 2 . 19 7, that (4) (we) last 21. I certify that (\$ (this hospital) attended the deceased from 1967 may be retained director, page 3 should should be filed with the 19 67, and that death accurred of M. from couses and on the date stated above. saw the deceased plive an 22o. SIGNATURE 22b DATE SIGNED ATTENDING STAFF M.D DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23o, BURIAL CREMATION. 23b DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County), (Stote)/ REMOVAL (Specify) REC'D BY REGISTRAR 25b REGISTRAR'S SIENATURE 24. FUNERAL DIRECTOR **ADDRESS** VR A15 (4) 20 M 1/66

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 03458 funeral s 1, and 2, frer death. requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COLINTY a. STATE b. COUNTY Garroll Mamrl and MARYLAND physician and completely fülled in by the ten please remave cachan pagéers. Pages aval, and in any event, within 72 haurs afte b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) write RURAL and give nearest town) Baltimore d. STREET ADDRESS e IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital give street address) ON A FARM? 1521 Schenley Road Springfield State Hospital YES NO [2] 3. NAME OF 4 DATE Month Day Year OF DECEASED Raymond Herman Moreau 19 DEATH 60 IF UNDER 24 HRS IF UNDER LYEAR S. SEX 6. COLOR OR RACE 7. MARRIED TX DATE OF BIRTH 9. AGE (In years **NEVER MARRIED** lost birthday) Months Haurs 7-28-07 Thite Mala WIDOWED DIVORCED COUNTRY? USA 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, at fareign country) 12 CITIZEN OF WHAT during most of working Lie, even if retired) INDUSTRY Maryland 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME or remayal. Otto Morcau Aumota Mir WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, ng, ar unknawn) (If yes give war ar dates at service INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) physician. DUE TO Conditions, if any, which gave rise ta immediate cause (a), DUF TO stating the underlying cause as the attending has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)

DSYCHOTIC FOR THE COMMITTEE CONTRIBUTION OF THE COMMITTE WAS AUTOPSY PERFORMED? action. NO TO FUNERAL DIRECTOR: After this certificate ī 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) 20g ACCIDENT WAS UNDERLYING [the hospital OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (State) factory, street, affice bldg, etc.) Haur a.m. at work at wark 21. I certify that (I) (this haspital), attended the deceased from 19 (7, that (1) (we) last Page 4 may be retained should and that death accurred at 1150 PM, from causes and an the date stated above. 19 D I saw the deceased alive an 22b. DATE SIGNED 22a. SIGNATURE **ATTENDING** M.D. PHYS 22d ADDRESS 22c PHYSICIAN S O HOSPITAL O Springfield NAME (Type) NAN director, should 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) 23a BURIAL CREMATION REMOVAL (Specify)
Burial 3/8/67 Dulanev Valley Baltimore Co., Md. 2Sb REGISTRAR S SIGNATURE 2Sq REC D BY REGISTRAR 24 FUNERAL DIRECTOR VR A15 (4) Wm. Cook-Brooks Inc. Baltimore, Md. 21202 1967



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03459 CERTIFICATE OF DEATH death, requires that the death certificate be executed within 24 haurs after death the attending physician and campletely filled in by the funeral sit permit. Then please remave carban papers. Pages 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. COUNTY o. STATE b. COUNTY Carroll MARYLAND Carroll b CITY OR TOWN (If autside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) papers. Pag hin 72 haurs o write RURAL and give nearest town) 9 Mos. Finksburg Westminster R.D. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e IS RESIDENCE ON A FARM? d. STREET ADDRESS Williams Nursing Home NO X YES | NAME OF First Middle Last 4. DATE Manth Dov Year DECEASED Cora F. event Myers March (Type or print) 19 67 DEATH SEX 6 COLOR OR RACE NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED last birthday) Months Days Haurs Female White Oct. 4, 1876 WIDOWED 50 DIVORCED 100 USUAL OCCUPATION (Give kind of work done 1Db KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
Housewife INDUSTRY COUNTRY? Own home Maryland IISA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME David Frock Lydia Bankard IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) 219-01-3109 Mrs. Harry Fesser Westminster, Md. No cremation. 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) INTERVAL BETWEEN burial-transit PART I, DEATH WAS CAUSED BY ONSET AND DEATH Cerebral Hemorrhage IMMEDIATE CAUSE (a) signed by DUE TO Conditions, if ony, which gave rise to immediate cause (a). DUE TO attending stating the underlying cause as the O FUNERAL DIRECTOR: After this certificate has been last WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) for use Arteriosclerotic C-V Disease YES NO 😾 Page 4 may be retained by the hospital ar 20g ACCIDENT WAS UNDERLYING [205. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH 0 detached (IF EITHER, NOTIFY MEDICAL EXAMINER) TOTLE Dept. (City or town) (Stote) 20d INJURY OCCURRED 2De. PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month, Day, Year (County) Hour a.m. factory, street, office bldg., etc.) Not While none 19 ot work 21. I certify that (I) (this stopping) attended the deceased from 6-11-66 . to 3-5-67 , 19 , that (I) (vie) lost , 19 3 shavid I with the S saw the deceased alive an Feb. 18 167, and that death occurred at 7. P. M. fram causes and on the date stated above. 22b DATE SIGNED 22a, SIGNATURE **ATTENDING** 3-6-67 M.D. DIRECTOR director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Caples, M. D. D. D. 6 Hanover Rd., Reisterstown, Md 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL, CREMATION, 23b. DATE THEREOF (County) (State) Burial Specify) March 8.196 Pleasant Valley Carroll Co. Md 24. FUNERAL DIRECTOR **ADDRESS** 2Sc REC'D BY REGISTRAR REGISTRAR S. SIGNATURE VR A15 (4) 1967 C.O.Fuss Son Taneytown, Md. 20 M 1/66



1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND				
4 20E 1	03460 CERTIFICATE OF DEATH	3454			
hours after death in by the funera is. Pages 1 and 2 is hours after death	1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, If Institution: If a. STATE // b. COUNTY	(esidence before admission)			
ifter the f es 1	MARYLAND MARYLAND	and alim magnet form			
by the Pages aft	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 8 Veq15 4/205 Bay fincte City Bay fincte City	, and give nearest (Owil)			
hour hour ed in ers. 72 ho	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?			
n 24 n 24 y fill pap thin 7	Long View Nursing Home. Inc 3031, Edge wood Ave	YES NO X			
executed within 24 hours afternove completely filled in by the femove carbon papers. Pages are eyent, within 72 hours af	3. NAME DE DECEASED (Type or print) ADD A H Nelson DEATH Nonth DECEASED ADD A H Nelson DEATH 3. NAME DE Month OF DEATH	Day Year 1967			
rted compaye	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years FUNDER				
and and	Pemale White WIDOWED DIVORCED NOV 7, 1888 78 yrs.				
e be considered and in	during most of working life, even if retired) INDUSTRY	OUNTRY?			
cate be ophysician n please	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	U.S.A			
ertifi Iing Ther emov	John Doelle Cetherie, Meisenfe	1det			
The law requires that the death certificate be executed within or attending physician. Cate has been signed by the attending physician and completely r use as the burial-transit permit. Then please femove carbon calth prior to burial, cremation, or removal, and in a present, with	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) 217-03-1913 D. George Nelson Manchestee	Marreland			
the ation	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN			
res that the physician. signed by th ourial-transit burial, cremat	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Armel Try rearest.	ONSET, AND DEATH			
sysici nysici nigne rial-t	Conditions, If any, which) DUE TO (I shierstends Carlo Cascal C	?			
quire ng ph sen s sen s te bu	gave rise to immediate cause (a), stating the DUE TO				
CIAN: The law requires that to ospital or attending physician. Certificate has been signed bed for use as the burial-tran hed for use as the burial, cret. of Health prior to burial, cret.	underlying cause last. (c)	119. WAS AUTOPSY			
or att or att ate h use alth p	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 202. ACCIDENT WAS UNDERLYING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	PERFORMED?			
Tiffical for for the of He	202. ACCIDENT WAS UNDERLYING TO AUSE OF DEATH OR CONTRIBUTING TO AUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
PHYSICIAN: the hospital this certific detached fo e Dept. of H		(04040)			
	Hour a.m. While Not While factory, street, office bldg., etc.)	unty) (State)			
OR ATTENDING be retained by lirectors. After is 3 should be	21 (certify that (!) (this hospital) attended the deceased from NOV 26, 1958, to March 17, 196	2, that (I) (we) last			
TTER etain Shou	saw the deceased alive on March 1 1967, and that death occurred at 8 a. M, from the causes and on the	the date stated above.			
OR A DE L	ATTENDING — MED. — STAFF — h	DATE SIGNED			
ITAL may RAL (22c. PHYSICIAN'S NAME (Type)	1 1			
TO HOSPITAL OR ATTENDI Page 4 may be retained O FUNERAL DIRECTOR. A director, page 3 should should be filed with the	Just 110 Just End Man	ounty) (State)			
Pa To Pa	238. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or consumption of the second seco				
2	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR Leonard J. Ruck, Inc. Balto. Md. 21214	'S SIGNATURE			
VR A15 (4) 15M 4-64	DATMAR 2 0 1967	A Very			

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03463 CERTIFICATE OF DEATH requires that the deoth certificate be executed within 24 hours after deoth physician and completely filled in by the funeral en please remover carbon papers. Pages 1 and oval, and in grify event, within 72 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution PLACE OF DEATH a. COUNTY o. STATE b. COUNTY Carroll Carroll MARYLAND b CITY OR TOWN (If auts de carparate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) write RURAL and give nearest town) Tanevtown Taneytown d. NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? the ottending physician and composers, sit permit. Then please remover-torbon papers mation, or removal, and in any event, within 72 h NO X E. Baltimore Street YES -E. Baltimore Street 3 NAME OF Middle 4. DATE Day Year DECEASED DEATH 1967 (Type or print) Ohler 23. IF UNDER Ethel Pauline March IF UNDER 24 HRS. S SEX AGE (n years 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH last birthday) Months Doys Haurs WIDOWED DIVORCED Female White 1893 10a USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR DIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of warking life, even if retired) INDUSTRY COUNTRY? ILS.A Housework

13. FATHER'S NAME Warvland 14. MOTHER'S MAIDEN NAME Anna Loretta Koons William Daniel Ohler IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give war or dates af service) Mr. Delmont Koons, Taneytown, Maryland 215-32-3213 INTERVAL BETWEEN ONSET AND DEATH 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) signed by the burial-tronsit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause Heolth prior to TO FUNERAL DIRECTOR: After this certificate hos been the 19. WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED' CERTIFICATION for 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I at Part II of item 18.) 20g ACC DENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (State) Not While factory, street, affice blda., etc.) of wark at wark 21. I certify that (1) (this haspital) attended the deceased fram Microch 5, 1967, ta March 17, 1961, that the (we) last saw the deceased alive an March 12, 1962, and that death accurred at 6 4 M, from causes and an the date stated above. Poge 4 may be retained director, page 3 should should be filed with the saw the deceased alive an March 22a SIGNATURI ATTENDING DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S Ambler Thompson NAME (Type) Taneytown. Md. director, 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230. BURIAL CREMATION 23b. DATE THEREOF REMOVAL (Specify).
Buria Grace Reformed Cemetery Mar. 25.1967 Taneytown, Maryland 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 C.O.Fuss & Son Taneytown, Maryland



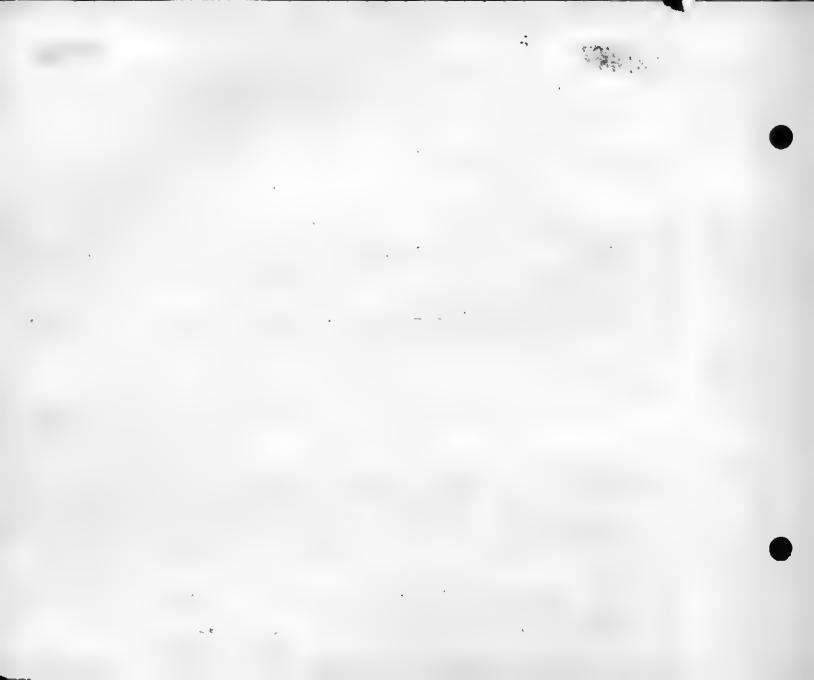
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 03465 e seroon filled in by the funeral e seroon opers Pages 1 and 2 yent with it 72 hours ofter death. 24 hours ofter death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission PLACE OF DEATH a. COUNTY o. STATE **b** COUNTY Carroll Maryl and MARYLAND CLENGTH OF STAY IN 16 CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, Sykesville davs Baltimore d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? the attending physician and completely filled in sit permit. Then please remove carban paper Springfield State Hospital 900 Cathedral Street YES NO IX PHYSICIAN: The law requires that the death certificate be executed within 3 NAME OF 4 DATE Month Last Day DECEASED (Type or print) RUTH LOUISE PRICE March 21 19 67 DEATH 9. AGE (n years IF UNDER 1 YEAR | IF UNDER 24 HRS. S. SEX 6 COLOR OR RACE DATE OF BIRTH 7 MARRIED NEVER MARRIED last burthday) Months Days Hours Female White DIVORCED 10-15-83:02 WIDOWED 10b. KIND OF BUSENESS OR 11 BIRTHPLACE (County & State, or fareign country) 10o USUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT during most of working ite, even if retired)

Bank empleyes red Moustry COUNTRY? Maryland U.S.A 14. MOTHER S MAIDEN NAME 13 FATHER'S NAME burial, cremotion, ar removal, Tully Price Annette B. White 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, na, ar unknown) (If yes give war ar dates af service) 220-24-3777 Records, Springfield State Hospital 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the buriol-transit p PART I. DEATH WAS CAUSED BY. ONSET AND DEATH Conjestive Heart Failure IMMEDIATE CAUSE (a) Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, if any, which gave Coronary Disease vears rise to immediate couse (a), DUF TO stating the underlying cause IO FUNERAL DIRECTOR: After this certificate has been Diabetes years PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY of Health p PERFORMED? Schizophrenic reaction, chronic undifferentiated type. NO YES 🗀 20a ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (State) 20c. TIME OF INJURY Manth, Day, Year (County) Not While factory, street, office bidg., etc.) at work 21. I certify that (I) (this hospital) attended the deceased from 3-17-, 1967, to 3-21-, 1967, that (I) (we) lost saw the deceased alive on March 21, 1967, and that death accurred at 11.361 M, fram causes and an the date stated above. 1967, that (I) (we) lost 22a. SIGNATURE 22b. DATE SIGNED STAFF PHYS. DIRECTOR director, page 3 should be filed v 75.T PHYS. 22d. ADDRESS PHYSICIAN'S Frances Reid Nabers, M. D. NAME (Type) Springfield State Hospital. Sykesville 230. BURIAL CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 3/25/67. 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) Loudon Park Cemetery Baltimore. Md. 25b. REGISTRAR'S SIGNATURE ADDRESS 2So REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214

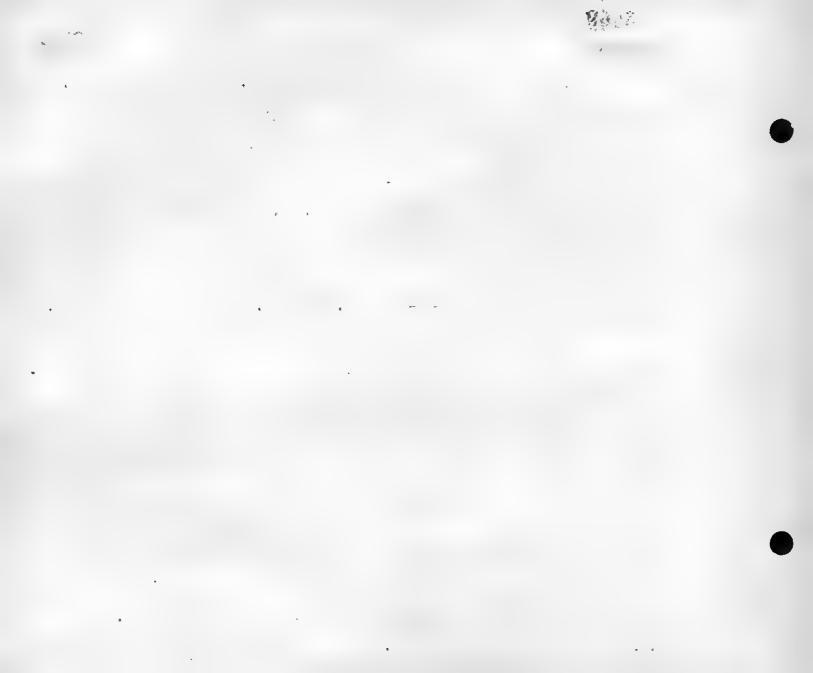




MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 03467 pup physician and campletely filled in by the funeral en please remove carban papers. Pages I and oval. and in any event, within 72 haurs after deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) g. COUNTY o STATE 6 COUNTY Carrol 3 MARYLAND Marvland requires that the death certificate be executed within 24 haurs after Carroll b. CITY OR TOWN (If outside corporate limits c. LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give necrest town) write RURAL and give nearest town) several hours Rural Taneytown Westminster d STREET ADDRESS IS RESIDENC d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) ON A FARM? Carroll County General Hospital Route # YES NO Se NAME OF M ddfe Lost 4. DATE Month Doy Year DECEASED
(Type or print) ÔF 23 19 Nevin Lake Ridinger DEATH IF UNDER 1 YEAR DATE OF BIRTH 9. AGE (In years LIF UNDER 24 HRS S KEX 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** lost birthday) Months Davs Hours WIDOWED DIVORCED Male White Aug. 27. 1895 10o USUA, OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 1) BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Painter Househainting II.S.A Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or remova John Ridinger Clara Shoemaker 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes at service) 17 INFORMANT 16. SOCIAL SECURITY NO. Address permit. Mrs. Golda Ridinger, R #1, Taneytown, Md. 200-09-54/7 crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) the transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: signed by the burial-trans IMMEDIATE CAUSE (a) DUE TO Canditions, if onv. which gove FRTERIOSCLERCTIC nse to immediate cause (a). DHE TO stating the underlying cause the haspital or attending as the TO FUNERAL DIRECTOR: After this certificate has been lost. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? Health p use NO far 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING [detached for the Dept. af H OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20d INJURY OCCURRED 20f. 20c. TIME OF INJURY Month, Doy, Year factory, street, affice bldg., etc.) Hour p.m. While Not While ot work at wark 21. I certify that (I) (this haspital) attended the deceased fram_ 3/23 , 1967 , to 19____, that (I) (we) last 3 should I with the S 1967, and that death accurred at 75M, from causes and an the date stated above. saw the deceased alive an 220. SIGNATURE 22b. DATE SIGNED ATTENDING STAFF 23/67 PHYS. director, page 3 should be filed v DIRECTOR PHYS 22d. ADDRESS 22c PHYSICIAN S NAME (Type) Vincent J Fiocco. Anchor Street, Westminster 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b DATE THEREOF (County) (Stote) Page 4 23o. BUR AL CREMATION REMOVAL (Specify) 27.1967 Lutheran Cemeterv Mar. Taneytown, Maryland 25b. REGISTRAR'S SIGNATURE 250 REC'D BY REGISTRAR FUNERAL DIRECTOR MAR 2 VR A15 (4) 1967 Milaria 20 M 1/66 C.O. Fuss & Son. Taneytown, Md



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 13462 CERTIFICATE OF DEATH 03468 requires that the death certificate be executed within 24 hours ofter death. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH filled-in by the funeral papers. Pages 1 and a. COUNTY a. STATE b. COUNTY Carroll Balto. MARYLAND b CITY OR TOWN (If autside carparate imits write RURAL and give nearest tawn) c LENGTH OF STAY IN 1b c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) ve carbon papers. Pag event, within 72 hours Reisterstown Westminster d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RES DENCE ON A FARM? Carroll County General Hospital Glen Falls Road YES NO [3 NAME OF First Middle Last 4 DATE Manth Year Day completely DECEASED Margaret Rimbey 19 67 A. March 11. Type or print DEATH JE UNDER I YEAR IF UNDER 24 HRS. S. SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years remove Manths birthday) Days Heurs Sept. 25. 1902 DIVORCED WIDOWED Female White 10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWILE 11 BIRTHPLACE (County & State or foreign country) 12. CIT ZEN OF WHAT 10b KIND OF BUSINESS OR COUNTRY ? INDUSTRY please the attending physician sit permit. Then please Maryland USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removol, Emil Jacobs Annie L. Landen 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Address (Yes, na, ar unknown) [(If yes give war ar dates of service) 220-12-8256 Mr. Claude E. Rimbey Reisterstown. Md. signed by the atter-burial-transit perm burial, cremotion, c No INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), PART I. DEATH WAS CAUSED BY ONSET AND DEATH. IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause as the prior to has been last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) NO X certificate for 20g ACCIDENT WAS UNDERLYING □ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form (City or town) (County) (State) O FUNERAL DIRECTOR: After this 20c. TIME OF INJURY Manth, Day, Year Hour a.m. factory, street, affice bldg., etc.) Nat While at wark at work 21. I certify that (1) (this haspital) attended the deceased from about 1947, that (i) (we) last 1967. to 9 Poge 4 may be retained | should 19 67, and that death occurred at M. from causes and on the date stated above. saw the deceased alive on apr filed with 22b. DATE SIGNED 22a SIGNATURE ATTENDING PHYS. M.D. director, poge should be filed 22d. ADDRESS 22c. PHYSICIAN'S 187 E. Main NAME (Type) should 23d. LOCATION (City or Town) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) 23a. BURIAL, CREMATION (County) REMOVAL (Specify)
Burial 3/14/67 Evergreen Memorial Finksburg, Md. ADDRESS 2So REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (41) J.F.Eline & Sons Reisterstown. Md. 20 M 1/66



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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 03470 requires that the deoth certificate be executed within 24 hours ofter death. the attending physician and dompletely filled in by the funeral sit permit. Then please remake carbon papers. Pages I and notion, or removal, and in any event-within 72 hours ofter death 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Carroll MARYLAND Marvland b CITY OR TOWN (If outside corporate limits, c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) LENGTA OF STAY IN 16 write RJRAL and give nearest town) /3 mos. Sykesville Baltimore 21202 d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM? Springfield State Hospital 36 Market Place YES 🗔 NO X 3 NAME OF First Middle 4. DATE Lost Year Doy DECEASED OF DEATH William **NMN** SHENK (Type or print) March 10 DATE OF BIRTH IF UNDER 1 YEAR S SEX 6 COLOR OR RACE AGE (In years IF JNDER 24 HRS 7 MARRIED NEVER MARRIED birthdoy) Months Doys Hours Settorced x white 1-25-1912 male WIDOWED 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 13 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN DF WHAT during most of work ng life, even if retired) INDUSTRY COUNTRY? Pennsylvania ILS. Porter 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME William J. Shenk - dec. - dec Marv 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) [if yes gave wor or dotes of service)
yes Nat 1 Guard 1930-16 SOCIAL SECURITY NO 17. INFORMANT Springfield State Hospital Records 171-09-2913 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit PART I DEATH WAS CAUSED BY ONSET AND DEATH Tuberculous pneumonia IMMEDIATE CAUSE (o) DUE TO signed | Pulmonary tuberculosis Conditions, if any, which gove vears nse to immediate couse (a), DUE TD stoting the underlying couse os the Page 4 may be retained by the hospital or ottending this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? for use Health YES X CBS assoc. with alcoholic intoxication with behavioral reaction. NO [20o ACC DENT WAS UNDERLYING [205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, 20f (City or town) (Stote) 20c TIME OF INJURY Month, Doy, Year Hour o m. 20d. INJURY OCCURRED (County) foctory, street, office bldg., etc.) Not While at work at work O FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased from 11-17-65 ta 3-10-67, 19, that (I) (we) last saw the deceased alive an 3-10-67 and that death accurred at 8:30 m from causes and an the date stated above. 19 22b. DATE SIGNED -22a SIGNATURE STAFF PHYS 3-11-67 DIRECTOR director, page 3 should be filed v Springfield State Hospital 22d ADDRESS PHYSICIAN S Antonius Glaha, M.D. NAME (Type) °21784 Sykesville, Maryland 23c NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF 23d LOCATION (City or Town) 230 BURIAL, CREMATION, (County) REMOVAL (Specify) Mar. 14.19 FONERALDIRECTOR VR A15 (4) 20 M 1/66

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1	MARYLAND STATE DEPARTMENT OF HEALTH División of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	03474 MEDICAL EXAMINER'S CERTIFICATE OF DEATH U3455
HEALTH DEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY 2. STATE 4. COUNTY 4. STATE 5. COUNTY
	Carroll Maryland Carroll
ssary mera ay b imen	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL end give nearest town) Rural Taneytown C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown
the fundaments of the fundamen	Rural Taneytown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE
- D#	ON A FARM?
2 S 2 S	3. NAME OF First Middle Last 1.4. DATE Month Day Year
PM3.	(Type or print) HARVEY WILLIAM SHORB DEATH 3 14 19 157
単点 難力	5. SEX 6. COLOR OR RACE 7 MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS last birthday) Months Days Hours Min.
death. I Pages ith form nd 2 w	Male White WIDOWED DIVORCED Nov. 6, 1925 41 yrs. MONTHS DAYS DAYS
ve ar	during most of working life, even if retired) Automobile Dealer Retail Sales Maryland U.S.A.
n 18. Gi	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
3 0 0	Edward Shorb Clara Ohler
24 0 111 111 111 111	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service)
within 2 pencil in miner's 0 permit. I	Yes WW II 212-24-3536 Mrs. Harvey W. Shorb, R#1, Taneytown, Md.
ted within in pencil i Examiner's sit permit. or removal	PART I. DEATH WAS CAUSED BY:
executed ding" in ical Examination of its strength of its stre	DUE TO 3/
	Conditions, if any, which (b) Hypertender towns of the contamp Time C
	cause (e), stating the DUE TO
should word ' Chief I as a k urial, ci	
EXAMINER: This certificate short certificate, writing the word rould be forwarded to the Chiles. R: Page 3 should be used as signated agent, prior to burial.	YES NO X
certification ded to prior	20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING COURS OF DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) CAUSE OF DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)
R: This cer sate, writin forwarded 3 should L agent, prid	CAUSE OF DEATH. Z 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State)
cate, for 3 s	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4 4 4 4 4 4 4 4 4
XAMINE certific ould be es. R: Page ignated	21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
EXAM le cert should files. OR: Pa	death resulted from: Natural causes Accident, Suicide, Homicide, Undetermined manner
re the the cour	ACTUAL CHIEF MEDICAL EXAMINER
MEDII kecute Page for you L DIRI	DEPUTY MEDICAL EXAMINER X
DEPUTY N lease exe irector. P etained fo FUNERAL f Health o	NAME (Type) W. Glenn Speicher had confinitely ignit and fully in the confinitely carroll
o DEPUT please of director. retained o FUNER of Healti	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)
E B	Burial Mar. 17, 1967 Reysville Gemetery Reysville Maryland 24. FUNERAL DIRECTOR // ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
VR A15ME	John H. Skiles C.O. Fuss & Son, Taneytown, Md. MAR I 6 1967 Junes Junes
3500 4-64	



1 2	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FUR STATE	02/79 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03466
HEALTH DEPT.	1. PLACE OF DEATH a. COUNTY b. COUNTY c. STATE c. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE c. D. D. COUNTY c. STATE c. STATE c. D. COUNTY c. STATE c. STAT
202 Ed	b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ecessal er funer may partme	RUTAL and give nearest town) RUTAL SUKESVILLE Minutes RUTAL SUKESVILLE :-/
to the Se safte	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
	Route 32 Koute YES NOW
The The	OF TYPE OF PRINT) RUTH ATTRIE SIMPKINS OF MARCH 14 1967
ith. If a form Promise 1, 2 with within	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 18 DATE OF BIRTH 19. AGE (In years FUNDER 1 YEAR FUNDER 24 HRS. last birthdey) Months Days Hours Mig.
ive Page	108. USUAL OCCUPATION (GIVE kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT
Give g wi	during most of working life, even if retired) INDUSTRY HOS PITA MANY HOS PITA COUNTRY?
n 18. Ge along pages In any	13. FATHER'S NAME
24 hor ltem Office and	Edward Devilbiss Josepha! 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
d within 29 pencil in miner's 0 permit. Premoval, removal,	(Yes, no, or unknown) (If yes give war or dates of service) 215-16-9614 MR. Stephen Simpkins-Sykesville, Md.
d with pental pe	18. CAUSE OF DEATH [Enter only one cause per lipe for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND BEATH
ecute If Ex If Ex ransit on, or	INDIFFIRITE CALLET (A) / //// / //// /////////////////////
se excendir edica rial-tr matic	Conditions, if eny, which (b)
Toate should be executed the word "pending" in the Word Chief Medical Exa used as a burial-transit to burial, cremation, or	cause (e), stating the DUE TO
e Short as buria	
to the use	YES NO STEE NO
CAL EXAMINER: This certificate should be executed within 24 hours after the certificate, writing the word "pending" in pencil in Item 18. G. 4 should be forwarded to the Chief Medical Examiner's Office along ur files. ECTOR: Page 3 should be used as a burial-transit permit. File pages sesignated agent, prior to burial, cremation, or removal, and in any	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS? PERFORMED? PERFORMED? YES NO SECURIBLE HOW INJURY OCCURRED. (Enter nature of bury in Part 1 or Part 11 or Part 12 or Part 11 or Part 12 or Part 11 or P
te, worwa	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED, 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)
TINER tiffica be 1	
the certificate should be a should be a files. CCOR: Page designated	21. I certify that I took charge of the remains described above, held an Autopsy, inspection [X], inquiry, and in my opinion death resulted from: Natural causes Accident [X], Suicide, Homicide, Undetermined manner
IEDICAL EXU cute the c age 4 shou r your files. DIRECTOR: r its design	ACTUAL CALLER MEDICAL EXAMINER () 22. BATE SIGNED
≥ 9 7 5 7 °	SIGNATURE WITH A AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA
O DEPUTY please en director. retained D FUNERA of Health	EXAMINER'S W. Glenn Speicher Deputy MEDICAL EXAMINER & STREET DEVELOPMENT STREET
please director. retained to FUNER of Healt	PREMOVAL Specify) 3-17-67 Woodlawn Comelegy BAltimore Md.
A.	25. FUNERAL DIRECTOR ADDRESS 256. REGISTRAR'S SIGNATURE
3500 4-64	Harry W Haight sykewille, Md. MAR 16 1967 gelianles Junge

A Burney

PLACE OF 2. USUAL RESIDENCE (Where deceased lived, if Institution, Residence before admission) a, STATE **b.** COUNTY MARYLAND CITY OR TOWN (if outside corporate limits, E. LENGTH OF STAY IN 16 OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest lown) NAME OF HOSPITAL OR INSTITUTION (if not In hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? 2500771 YES NO Z 3. NAME OF DATE Month DECEASED OF (Type or pont) DEATH 196 6. COLOR OR RACE 7. MARRIED THEYER MARRIED DATE OF BIRTH IF UNDER 24 HRS. AGE (In years | IF UNDER 1 YEAR lasi birthday) Months Days WIDOWED DIYORCED [physician JSUAL OCCUPATION (Giva kind of work 12. CITIZEN OF WHAT COUNTRY? & State, or foreign country) done during most of working life, avan if refired) 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME INFORMANT 16. SOCIAL SECURITY NO.1 17. (Yes, no, or unknown) (If yes give war or dates of service) 18. CRUSE OF DEATH |Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Lewistonial IMMEDIATE CAUSE (a) DUE TO descendan colon Conditions, if any, which gave rise to immediate cause **DUE TO** (a), stating the underlying cause last, PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1 6) 19. WAS AUTOPSY PERFORMED? NO S 2De ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) OF CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d, INJURY OCCURRED 1 20e, PLACE OF INJURY (Home, Jerm, ' 20f. (City or Jown) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) While Not While Hour a.m. at work at work p.m. 10 . 3 19 (, , that () (we) last 21. I certify that (I) (this hospital) fattended the deceased from... saw the deceased alive on 22a. SIGNATURI ATTENDING STAFF PHYS. DIRECTOR PHYS. M.D. ADDRESS 224. 22c. PHYSIC AN'S NAME (Type) rector, 23a, BURIAL, CREMATION, 1 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) OH 25a, REC'D BY REGISTRAR 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 15M 7,61

DIVISION OF STATISTICAL RESEARCH AND RECORDS.

RTMENT OF HEALTH

W. PRESTON STREET, BALTIMORE 1, MARYLAND



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 24 hours after death. funeral PLACE OF DEATH a. COUNTY USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. COUNTY Carroll by the MARYLANO C1TY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d completely new Pages you's carbon papers. Pages within 72 hours at c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 mes Sykerwille **Baltimore** d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d.3716 Mohawk Avenue e. IS RESIDENCE ON A FARM? Springfield State Hospital W. Rogers Avo. NO X YES The law requires that the death certificate be executed within 3. NAME OF First Middle Last 4. DATE Month Oav and c. remové co. rhy event, w DECEASED DF DEATH (Type or print) 19 6 5. SEX 6. COLOR OR RACE 17. MARRIED TO NEVER MARRIEO DATE OF BIRTH AGE (In years I I FUNOER 1 YEAR I I F UNDER 24 HRS (1st birthday) Months Oays Hours 3-8-1880 WIDOWED Male OIVORCED 10a. USUAL OCCUPATION (Give kind of work done) 10b. KINO OF BUSINESS OR physician in please r .5 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? U. S.A C. S. Herring and Co. Baltimore. Md. 13. FATHER'S NAME 14. MOTHER'S MAJOEN NAME been signed by the attending ph the burial-transit permit. Then in to burial, cremation, or removal XXXXXX John W. Snyder XXXXXX Annie 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITYNO. John S. Snyder-25 Fairview Rd. Scarsdale Address (Yes, no, or unkown) | (If yes pive war or dates of service) unknorm Records. Springfield State Hospi 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND OEATH PART I, DEATH WAS CAUSED BY: PHYSICIAN: The law requires that the hospital or attending physician. IMMEDIATE CAUSE (a) HIWX DUE TO Rheumantic and arteriosclerotic heart disease. Conditions, If any, which (b) vears gave rise to immediate **OUE TO** cause (a), stating the as th underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY certificate h hed for use it. of Health p PERFORMED? Chronic brain syndrome assoc. with senile brain disease and YES X CERTIFI 20a. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) detached f te Dept. of MEDICAL 20c. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURREO 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. Not While fter ATTENDING 19 at work at work FUNERAL DIRECTOR: Af lirector, page 3 should I hould be filed with the S from 1-29-66, 19 to 3-25, 19 47, that (1) (we) last and that death occurred at 8.30 M, from the causes and on the date stated above. 3 - 25-19 67, that (i) (we) last 21. I certify that (I) (this hospital) attended the deceased from 24 saw the deceased alive on 19 67 22a. SIGNATURE 22b. DATE SIGNED director, page should be filed ATTENOING Page 4 may 1 DIRECTOR PHYS. M.O. PHYS. PHYSICIAN'S (22c. 22d. ADDRESS NAME (Type) LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, REMOVAL (Specify) 2 Loudon Park Cemetery Burial 3 - 28 - 67 Baltimore, Maryland FUNERAL DIRECTOR ADDR ESS MAR 2 9 1967 Ellsworth Armacost-4600Liberty HeightsAve. VR A15 (4)

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MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 03475 requires that the death certificate be executed within 24 haurs after death. and campletely filled in by the funeral femave, carban papers. Pages 1 and 3 in asyvevent, within 72 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE b. COUNTY Maryland Carroll
b CITY OR TOWN (If outs de corporate l'mits, MARYLAND Baltimore Citv C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) write RURAL and give neorest town) Baltimore Sykesville davs d. STREET ADDRESS B IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital 839 Eutaw Street YES NO DE 3 NAME OF 4 DATE Middle First Lost Month Day Year DECEASED (Type or print) JOSEPH BARKTELL SPELLMAN MAR (H 2 67 19 DEATH **Day**wever 8 DATE OF BIRTH IF UNDER 1 YEAR | 1F UNDER 24 HRS. S SEX 6 COLOR OR RACE 9 AGE (In years 7. MARRIED NEVER MARRIED 64 yrs Manths Days Hours 8-15-02 Male White WIDOWED Ben DIVORCED 10c USUA, OCCUPATION (Give kind of work done during most at working life, even if retired) 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT U.S.A. INDUSTRY the attending physician sit permit. Then please, and Maryland Painter 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME William Spellman (last name unk. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) 1926-1927 216-07-6460 Records, Springfield State Hospital Yes 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH Pyogenic abscess, left lung IMMEDIATE CAUSE (a)_ DUF TO Conditions, if only, which gove Bronchopneumonia, bilateral days rise to immediate couse (a), lung DUE TO stating the underlying cause 10 FUNERAL DIRECTOR: After this certificate has been as the Moderate pulmonary tuberculosis, upper right years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? use YES X NO be retained by the haspital ar far 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, (City or town) (Caunty) (State) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED Not While factory, street, affice bldg., etc.) ot wark ot wark shauld be 103-2-67 21. I certify that (I) (this haspital) attended the deceased from 2-27-67 19___, that (I) (we) last and that death accurred at 7:00 3-2-67 M. fram causes and an the date stated abave. saw the deceased alive an___ 22g SIGNATURE 22b. DATE SIGNED ATTENDING MED. DIRECTOR 3-3-67 \square < ~ ~ M.D. director, page shauld be filed 22d. ADDRESSpringfield State Hospital 22c PHYSICIAN'S NAME (Type) Antonius Glahn: M. D. Sykesville, Marvland 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 23a. BURIAL, CREMATION 23b. DATE THEREOF (Stote) REMOVAL (Specify) St. Mary's Cemetery Hampden Baltimore, Md. 3-6-67 2Sb. REGISTRAR'S SIGNATURE 2So REC'D BY REGISTRAR 24. FUNERAL DIRECTOR ADDRESS VR A15 (4) § 20 M 1/66 (rcharles Wm. Cook-Brooks Inc. 1217 St. Paul Street DATE IN A IX



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03470 CERTIFICATE OF DEATH 03476 24 haurs after death. funeral I and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY o STATE b. COUNTY Carroll Maryland Daltimore City

C CITY OR TOWN (if outside corporate limits write RURA, and give nearest town) MARYLAND pan papers. Pages I within 72 haurs after filled in by the fun n papers. Pages 1 b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 Baltimore Sykesville d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Springfield State Hospital 1321 Eutaw Place NO X YES [law requires that the death certificate be executed within Middle NAME OF OATE remave carban n any event with First Month Year the attending physician and completely sit permit. Then please remave carban OECEASEO (Type or print) OF DEATH Ada Glark Spridell March 19 IF UNDER 1 YEAR S SEX 6. COLOR OR RACE B. DATE OF BIRTH AGE (n years IF HNDER 24 HRS. 7 MARRIED **NEVER MARRIEO** hirthdoy) lost Months Oovs Hours Female Negre 11-1-96 134 WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT and in during most of working life, even if retired) **INDUSTRY** COUNTRY? Maryland Laundress 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar removal, Charles Ridgley unknewn 17 INFORMANT Records WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. (if yes give wor or dotes of service) Springfield State Moseital, Sykesville, Md. Nene crematian. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), signed by the burial-transit p ONSET AND DEATH PART ! OFATH WAS CAUSED BY Gardiae failure due to myecardial infarction OTTS IMMEDIATE CAUSE (a) physician DUE TO Years Nephrescleresis Conditions, if any, which gove rise to immediate couse (a). DUE TO attending | stoting the underlying couse as the hos been last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO Page 4 may be retained by the haspital or IO FUNERAL DIRECTOR: After this certificate þ 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING [3] OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) Dept. 20e. PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED (City or town) (County) (Stote) Hour o.m Not While factory, street, office bldg., etc.) of work of work 21. I certify that (1) (this haspital) attended the deceased fram July 26 , 19.65 , to March h _, 19**.6.7**, that (I) (we) last shauld saw the deceased alive an March k 1967 , and that death accurred at M, fram causes and an the date stated above. March 4, 1967 22o. SIGNATURE 8 DIRECTOR r, poge 3 be filed 22d. ADORESS SPINETICLE State Assertal NAME (Type) Naci Buyukunsal, M. D. Sykesville. Marvland directar, shauld be 23o BURIAL, CREMATION, NAME OF CEMETERY OR CREMATORY 28d a OCATION (City or Jown) 23b OATE THEREOF (County) (Stote) REMOVAL (Specify) 120 ADDRESS 24 FUNERAL DIRECTOR 2So. REC'O BY REGISTRAR 1/25b RECISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 1967



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 03477 requires that the death certificate be executed within 24 haurs after death. death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) by the attending physician and campletely filled in by the funeral transit permit. Then please remave carban papers. Pages I and PLACE OF DEATH o. COUNTY o STATE b. COUNTY Baltimore City MARYI AND Maryland Carrel! b CITY OR TOWN (If autside carparate limits, c. City OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 write RURAL and give nearest town) an papers Pag within 72 haurs Baltimore Svkesville 8 days d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM? Springfield State Hospital 336 Ilchester Ave. YES NO IX NAME OF First Middle 4. DATE Lost Month Doy Year DECEASED (Type or print) OF DEATH JAMES STARKEY MARCH 19 67 **JEFFERSON** IF JNDER 1 YEAR | IF UNDER 24 HRS S SEX 9 AGE (In years NEVER MARRIED DATE OF BIRTH 6 COLOR OR RACE 7. MARRIED 50 berthdoy) Months Dovs Hours 2-28-17 White Male WIDOWED DIVORCED 10a USUA, OCCUPAT ON (Give kind of work done RIRTHPLACE (County & State, or foreign country)
Baltimore 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even fretired)
Stock Clerk P.Cann Co. COUNTRY? Maryland U.S.A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal. Anna Annabelle Noll James Samuel Starkey IS WAS DECEASED EVER IN J.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) Unk. Records. Springfield State Hospital No cremation, 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) INTERVAL BETWEEN signed by the burial-transit p WOOKS DEATH PART I. DEATH WAS CAUSED BY: Right heart failure IMMEDIATE CAUSE (a) DHE TO Severe bilateral emphysema Years Conditions, if any, which gave 3 rise to immediate couse (a), DUE TO stoting the underlying couse or attending r te O FUNERAL DIRECTOR: After this certificate has been Inst. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) YES X NO [far 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING Page 4 may be retained by the haspital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) factory, street, office bldg , etc } Hour o.m. Not While of work ot work and that death accurred at :00 , 19___, that (I) (we) last 21. I certify that (1) (this hospital) attended the deceased from Martin causes and an the date stated above. shauld 3-5-67 saw the deceased alive on_ 22o. SIGNATURE 22b DATE SIGNED ATTENDING 3-6-67 X DIRECTOR PHYS M.D. 22d ADDRESS Springfield State Hospital 22c PHYSICIAN S Sykesville, Maryland NAME (Type) Octavio A. Ruiz, M. D. director, shauld 23d. LOCATION (City of Town) 23c. NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF (County) (Stote) 23o BUR AL CREMATION REMOVAL (Specify) Baltimore, Md. 3/9/67 Baltimore Cemetery chimunek Funeral Home, Inc. 3331 Brehms Lane 250 RECED BY REGISTRAR 196 24. FUNERAL DIRECTOR Charley VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH



1	1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	1
-	O/:	03480 CERTIFICATE OF DEATH 03	3474
r death		1 PLACE OF DEATH COUNTY Carroll MARYLAND 2 USUAL RESIDENCE (Where deceased lived, if institution Residence of STATE Maryland b. COUNTY Balti	more City
urs afte	Poge Turs oft	b. CITY OR TOWN (If outside corporate limits, Sykente RURAL and give gegrest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give most sykente RURAL and give gegrest town) 29yrs.8mo.12da. Baltimore, City	
n 24 ha	physician and completely filled in by then pleases. Pogoval, and in anyevent, within 72 haurs	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital ?	e. IS RESIDENCE ON A FARM? YES NO
d within	letely fi corbon nt, with	3 NAME OF First Middle Lost 4. DATE Month OF DECEASED (Type or print) Mary Louise Turlington DEATH March	Day Year 25 19 67
execute	d comp	Female with widowed Divorced To-13-19-00 18 yrs	Doys Hours Min.
ate be	eoso da din on and in o	during most of working life, even if retired) Music Teacher Unknown Virginia	EN OF WHAT
certific	g physi Then pi moval,	13. FATHER'S NAME Samuel Turlington 14. MOTHER'S MAIDEN NAME Mary Ames	
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death be retained by the hospital or attending physician. SIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by the funeral as should be detached for use as the buriol-transit permit. Then please corbon papers. Page Farth and with the State Dept. of Health prior to buriol, cremation, arremoval, and in onvervent, within 72 haurs often death.	ttendin ermit. n, or rei	15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or doles of service) 220-54-6026 Hospital Records Sykesville, M	id.
	y the o ansit pe ematio	18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Presumanta Heart failure	ONSET AND DEATH
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IG PHYSICIAI the hospital the this certifice deflucted fo		p.m. 17 of work — of work —	
TENDI	DIRECTOR: After By Should be ed with the Store	21. I certify that (I) (this haspital) attended the deceased fram July 17, 1937, toMarch 25, 1967 saw the deceased alive anMarch 25, 1967, and that death accurred atM, fram causes and an the	date stated above.
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O HOSPITAL	MERAL D for, pog	NAME (Type) Orlando 10. 194 MOS M.D. Stringfield State Cooperat	16
TO HO	To FUN direct shoul	THINOVAL (Specify 3-27-67 Mt. HOLLY CEM. ONANCOCK,	ounty) (State)
	VR A15 (4) 20 M 1/66	24. FUNERAL DURECTOR 250 AND	Judge



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	er deat	1.	PLACE OF DEATH a. COUNTY ARROLL MARYLAND 2. USUAL RESIDENCE a. STATE MARYLAND ARROLL MARYLAND	(Where deceased lived, If Institution: R	RRDOLL
	hours after d in by the f. Pages hours afte	R	b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if on write RURAL and glyg nearest town) VR AL WESTMINSTA I VEAR RURAL	utside corporate limits, write RURAL WESTMIN	STEN /
	fille paper in 72		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 224 WINCHESTER DRIVE 224 WI	NCHESTER D	9. IS RESIDENCE ON A FARM? YES NO H
	rted within 24 h completely filled ve carbon paper event, within 72		CARL CLEVELAND TWIGG	4. DATE MONTH OF DEATH MARCH	1 by Year 1967
	executec and con remove any eve	1	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH WIDOWED DIVORCED 1 21.8	9. AGE (In years IF UNDER last birthday) Months 78 yrs.	1 YEAR IFUNDER 24 firs. Days Hours Min.
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	eath certificat attending phy ermit. Then p en, or removal,	13	AUSTIN DAVIS TWIGG NANNI	E JANE BU	RDINE
	death c ne atten permit. ion, or 1	(Y)	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT PLY WEST OF UNKNOWN) (If yes give war or dates of service) 221-05-5057 WEST OF TAX	ADATIONS CV	DULANY
	at the death sian. ed by the ath transit perm cremation,		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Careana		INTERVAL BETWEEN ONSET AND DEATH
	lires that the physician. n signed by the burial-transit burial-transit burial, creme		Conditions, if any, which gave rise to immediate (b)	lon	
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	Page 4 may 0 FUNERAL Didirector, page should be fill	-	22c. PHYSICIAN'S NAME (Type) Soft N S. HARSHEY, M.D. & Conche	at western	æ, ud:
	Par of sho	238	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 3/8/67 FUNERAL DIRECTOR ADDRESS 1 256, REC'I	23d. LOCATION (City, town or col	etu ml.
	VR A15 (4) W 15M 4-64	1	2.5. myers, Jr. WASTMINSTER MI, 2115 / DATE MA	DO A ISLA	eles Jungs

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH-USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY COUNTY a. STATE hours after MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1D c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled B. IS RESIDENCE d. STREET ADDRESS DN A FARM? nt, within YES NO completely NAME OF Middle DATE Month Day Last 4. Year DECEASED 3 (Type or print) DEATH 19 AGE (In years | IFUNDER 1 YEAR | FUNDER 24 HRS. | last birthday) | Months | Days | Hours | Min. 5. SEX 6. COLOR OR RACE DATE OF BIRTH ev 7. MARRIED 7 NEVER MARRIED emove and in any WIDOWED DIVORCED 12. CITIZEN OF WHAT COUNTRY? 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY physician in please r (County & State, or foreign country) E certificate removal, 13. FATHER'S NAME attending print. Ther s been signed by une extra s the burial-transit permit. for to burial, cremation, or re 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMAN' Address death (Yes, no, or unkown) (If yes give war or dates of service) CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)c) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: the hospital or attending physician. IMMEDIATE CAUSE (a) **DUE TO** Conditions, If any, which gave rise to immediate DUE TO cause (a), stating the TO FUNERAL DIRECTOR: After this certificate has by director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONTRIBUTION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) WAS AUTOPSY PERFORMED? 19. YES [No. 208. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTHY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm.) (State) 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While Not While .be retained by 19 p.m. at work 21. I certify that (I) (this hospital) attended the deceased from 1961, to. 19.6.7, and that death occurred at 3.P.M. from the causes and on the date stated above. saw the deceased alive on 22a. SIGNATURE 22b. DATE SIGNED PHYS. DIRECTOR M.D. PHYS. Page 4 may ADDRESS PHYSICHANIS NAME (Type) 22d. LOCATION (QIty, (State) BURIAL, CREMATION. DATE. REMOVAL (Specify) UNERAL DIRECTOR BY REGISTRAR VR A15 (4) 15M 4-64

RESTON STREET, BALTIMORE 1, MARYLAND DIVISION OF STATISTICAL RESEARCH AND RECORDS OF DEATH 1. PLACE OF DEATH 2. USUAL REGIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTX a. STATE b. COUNTY MARYLAND b. CITY OR JOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If owinde corporate limits, write RURAL and give nearest town) write RURAL axid give/nearest town) ander d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street addess e. IS RESIDENCE ON A FARM? YES NO papers. n 72 hor completely NAME OF M dale DATE Month Year Dev DECEASED OF (Type or print) DEATH 19 within and cor 5. SEX AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED last birthday) Months DIVORCED physician 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY! done during most of working life, even if relired) 13. FATHER'S NAME 5 15. WAS DECEASED EVER IN U.S. ARMED FORCES? , 16. SOCIAL SECURITY NO. Addra (Yes, no, or unkown) | (Ifyesgive war or dates of service) 18. CAUSE OF DEATH (Enter only one cause per line for INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the underlying PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6), 19, WAS AUTOPSY CERTIFICATION PERFORMED? 20b DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d, INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, 1 20f (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg . etc.) While Not-While MEDI Hour a.m. at work el work 19 21. I certify that (I) (this hospital) attended the deceased from Mich. . L., and that death occurred at 3 from the causes and on the date stated above 22b. DATE 22a. SIGNATURE ATTENDING SIGNED DIRECTOR PHYS, M D death. Page 4 O FUNERAL ADDRESS 22c PHYSICIAN 23c. NAME OF CEMETERY OR CREMATORY 236. BURIAL, CREMATION, 1236 DATE THEREOF 23d, LOCATION (City, town or county) (Slete REMOVAL (Specify) 0 Grace Reformed Cemetery Burial Taneytown. Maryland 24 JUNERAL DIRECTOR'S SIGNATURE **ADDRESS** VR A15 [4]/ C.O. Fuss & Son Taneytown, Md.

NT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the deoth certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) and PLACE OF DEATH a. COUNTY b. COUNTY ARROLL MARYLAND c. LENGTH OF STAY IN 15 b CITY OR TOWN (If autside carparate limits, CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) write RURAL and give nearest tawn SYRS. d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS CARROLL CO. GEN. HOSPITAL NO Z YES 3 NAME OF Firs? Middle 4. DATE Manth Year DECEASED 0F CHARLES 1967 WEIGATE (Type or print) DEATH S SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH last birthday) DIVORCED 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 10g USUAL OCCLIPATION (Give kind of work done during most of warking life, even if retired) INDUSTRY COUNTRY? ANNE ARUNDE! 13 FATHER'S NAME STORE 14. MOTHER'S MAIDEN NAMI or removó WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT (Yes, na, or unknown) (If yes give war ar dates of service) CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) burial-transit PART 1 DEATH WAS CAUSED BY REBRAL IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave ARTERIC SCREECSIS rise to immediate cause (a). DUE TO stoting the underlying couse the hos been last. WAS AUTOPSY PERFORMED? YES NO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CCHIE PINL 12 MARCTION O FUNERAL DIRECTOR: After this certificate 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18) 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d, INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Day, Year Haur o.m. factory, street, affice bldg, etc.) Not While 196- Z, to , 1967, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased from_ 1967, and that death accurred at 925M, fram causes and an the date stated above. saw the deceased alive an 22a. SIGNATURE DATE SIGNED ATTENDING actions director, page 3 should be filed v DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S 10cco NAME (Type) U/NCEN 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) ALLEY /25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR Melianter DATE

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. 2. USUAL RESIDENCE (Where deceased lived, If instriution; Residence before admission) 1. PLACE OF DEATH a. COUNTY b. COUNTY a. STATE Baltimore Gitv Carroll MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) funeral b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b Мау 23vrs.9mos.18dys. Sykesville Baltimore the. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? delay ind 3 to 18. State hours Springfield State Hospital 1821 W. Mulberry Street NO X and 3. 3. NAME OF First Middle Last DATE Month Day Year DECEASED LATIRA MAY DEATH (Type or print) WHEELER 1967 MARCH death. If a e Pages 1, vith form 6. COLOR OR RACE | 7. MARRIED DATE OF BIRTH AGE (In years | IFUNDER 1 YEAR | FUNDER 24 HRS. NEVER MARRIED TO last birthday) Months Davs Hours Female White DIVORCED WIDOWED | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRY? U.S.A. Maryland Stenographer
13. FATHER'S NAME Calvert School 14 MOTHER'S MAIDEN NAME Pag Alfred Wheeler Mary Tucker File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes. no. or unkown) (If yes give war or dates of service) permit. removal, 219-05-1104-11 Records. Springfield State Hospital None 18. CAUSE OF BEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: ial-transit 5 Acute pseudo-membranous pvelonephritis days IMMEDIATE CAUSE (a) burial-trans cremation, o DUE TO Conditions, if any, which (b) gave rise to immediate DUE TO cause (a), stating the the word ' rc used as a to burial, underlying cause last (c) Acute vegetative endocarditis of mitral valve PART JL. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? Bchizophrenic reaction, paranoid type. YES Y NO F 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of injury in Part 1 or Part 11 of Item 18.) CERTI PRIMARY TO OF CONTRIBUTING CAUSE OF DEATH. 3 should bagent, price CAL 20e, PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, office bldg., etc.) Hour a.m. MED Not While at work at work 21. I certify that I took charge of the remains described above, held an Autopsy , inspection inquiry and in my opinion Fles. DIRECTOR: Undetermined manner death resulted from: Natural causes x/ Accident Suicide Homicide CHIEF MEDICAL EXAMINER Your **BATE SIGNED** ASSISTANT MEDICAL EXAMINER SIGNATUR 6 director. Paretained for 0 FUNERAL I DEPUTY MEDICAL EXAMINER X EXAMINER'S J. Glenn Speicher BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY 0.0 Aurial
24. FUNERAL DIRECTOR March 25/67 Western Cemetery VR A15ME Richard V. Sinoleton Glen Burnie, Md. 3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

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	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND,	
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ding	Cole Winner amy Gerg.	
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cian character crimit	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY,	
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r us pric	20s. ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJUST OCCURED. (Enter nature of injury in Part of Part II of item 18.)	
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E September 200	20e. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY-(Home, Iarm, 20f. (City or town) (County) (State) Hour a.m. Whila Not Whila lactory, street, office bldg., etc.)	
de de la companya de	Hour a.m. p.m. 19 Whila Not Whila lattery, sileer, office blugs, etc.)	
De	21. I certify that (I) (this haspital) attended the deceased from March 2.7, 19.61, to Jackh. 2.7, 19.61, that (I) (we)	
and on the	saw the deceased alive on	
A S S	228. SIGNATURE ATTENDING ATTEND	NED
A P S S S S S S S S S S S S S S S S S S	M.D. PHYS. DIRECTOR PHYS.] 3/28/6/	
Y ER	NAME (TYP) ASENTE (B) US h MD DVAMPSTEAD Marylend	
HE GE	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)	
0 g g g g	REMOVAL (Specify) 4/1/67 EVERGREEN MEMORIAL FINKS BURG MD	
VR A15 (4)	24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 250 REGISTRAR 256 REGISTRAR 256 REGISTRAR 260 ATURE	
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MARYLAND STATE DEPARTMENT OF HEALTH

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